

0001

1 AFTERNOON SESSION 1:35 P.M.

2 WEDNESDAY, JANUARY 20, 1999

3 \*\*\*\*\*

4 THE COURT: OKAY. WE'RE BACK ON THE RECORD.  
5 GOOD AFTERNOON, EVERYBODY. AND WE'RE READY FOR OUR NEXT  
6 WITNESS.

7 I THINK, BY WAY OF EXPLANATION, YOU HAVE AN  
8 UNDERSTANDING THAT THE PLAINTIFF WILL BE CALLED BACK TO  
9 TESTIFY FURTHER?

10 MS. CHABER: TOMORROW.

11 THE COURT: TOMORROW.

12 AND THAT IT'S AGREEABLE THAT WE INTERRUPT THAT  
13 EXAMINATION AND TAKE THE NEXT WITNESS NOW?

14 MR. OHLEMEYER: YES. YES, YOUR HONOR.

15 THE COURT: OKAY. WHO WILL IT BE?

16 MS. CHABER: THANK YOU. DR. BARRY HORN.

17 TESTIMONY OF

18 BARRY R. HORN, M.D.,

19 A WITNESS CALLED ON BEHALF OF THE PLAINTIFF, HAVING BEEN  
20 DULY SWORN, TESTIFIED AS FOLLOWS:

21 THE CLERK: PLEASE STATE YOUR NAME.

22 THE WITNESS: BARRY R. HORN, H-O-R-N.

23 THE CLERK: IS BARRY B-A-R-R-Y?

24 THE WITNESS: RIGHT.

25 THE CLERK: THANK YOU. PLEASE TAKE THE STAND.

26

27 DIRECT EXAMINATION

28 MS. CHABER: Q. GOOD AFTERNOON, DR. HORN.

JUDITH ANN OSSA, CSR NO. 2310

0002

1 A. GOOD AFTERNOON.

2 Q. COULD YOU TELL THE JURY WHAT TYPE OF A DOCTOR YOU  
3 ARE.

4 A. I'M A PULMONOLOGIST. I SPECIALIZE IN LUNG  
5 DISEASES, AND I'M ALSO A CRITICAL CARE SPECIALIST.

6 Q. AND WHAT IS THAT?

7 A. I TAKE CARE OF PEOPLE WHO ARE SICK AS HELL IN THE  
8 ICU.

9 Q. AND WHERE DO YOU DO THAT?

10 A. ALTA BATES MEDICAL CENTER IN BERKELEY.

11 Q. HOW LONG HAVE YOU BEEN DOING THAT?

12 A. I HAVE BEEN IN PRACTICE IN BERKELEY SINCE 1976.

13 Q. CAN YOU GIVE US A LITTLE SUMMARY OF YOUR  
14 EDUCATIONAL BACKGROUND.

15 A. WELL, I WENT TO UNDERGRAD SCHOOL AT CORNELL FROM  
16 1960 TO '64. I MAJORED IN CHEMISTRY. FROM 1964 TO 1968, I  
17 WENT TO MEDICAL SCHOOL AT THE STATE UNIVERSITY OF NEW YORK,  
18 DOWNSTATE STATE MEDICAL CENTER IN NEW YORK, AND I GRADUATED  
19 IN 1968.

20 FROM 1968 TO 1969, I WAS AN INTERN IN INTERNAL  
21 MEDICINE, WHICH IS THE STUDY OF ALL OF THE DISEASES OF THE  
22 BODY, AT MICHAEL REESE HOSPITAL IN CHICAGO. FROM 1969 TO  
23 1971, I CONTINUED MY TRAINING IN INTERNAL MEDICINE AT THE  
24 UNIVERSITY OF CHICAGO HOSPITALS AND AT MICHAEL REESE  
25 HOSPITAL.

26 THEN, FROM 1971 TO 1974, I DID MY TRAINING IN  
27 PULMONARY DISEASES AT STANFORD. DURING THAT TIME, I WAS AN  
28 INSTRUCTOR IN THE DEPARTMENT OF PHYSIOLOGY IN THE MEDICAL

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0003

1 SCHOOL, TEACHING THE MEDICAL STUDENTS HOW THE LUNGS WORKED.

2 I DID A LOT OF BASIC AND CLINICAL RESEARCH. I SPENT A FAIR

3 AMOUNT OF TIME ON THE CLINICAL SERVICES.

4 DURING MY THIRD YEAR AT STANFORD, I WAS MEDICAL  
5 DIRECTOR OF THE RESPIRATORY THERAPY DEPARTMENT AT STANFORD,  
6 WHICH IS ONE OF THE CLINICAL DEPARTMENTS WHICH DELIVERS CARE  
7 TO PEOPLE WHO ARE HOSPITALIZED AT STANFORD.

8 Q. OKAY. AND FROM THERE, DID YOU COME TO ALTA  
9 BATES?

10 A. NO.

11 Q. WHAT DID YOU DO NEXT?

12 A. I SPENT TWO YEARS IN THE U.S. AIR FORCE. THAT  
13 WAS FROM 1974 TO 1976. I WAS STATIONED AT THE AIR FORCE'S  
14 WORLDWIDE CENTER FOR LUNG DISEASES, WHICH WAS IN BELLEVILLE,  
15 ILLINOIS. WE HAD ABOUT ONE-THIRD OF A 250-BED HOSPITAL  
16 ENTIRELY DEVOTED TO TAKING CARE OF PATIENTS WITH LUNG  
17 DISEASE.

18 IF YOU WERE ON ACTIVE DUTY IN THE AIR FORCE AT  
19 THE TIME OR IF YOU WERE A DEPENDENT OF ACTIVE DUTY PERSONNEL  
20 OR YOU WERE A RETIREE AND GOT CARE AROUND AN AIR FORCE BASE  
21 ANYWHERE IN THE WORLD AND YOU HAD A MAJOR LUNG PROBLEM WHICH  
22 COULD NOT BE DEALT WITH LOCALLY, YOU WERE SENT BY HOSPITAL  
23 PLANE TO US IN THE MIDDLE OF THE CORNFIELDS  
24 AND SOY BEAN FIELDS IN ILLINOIS. WE HAD OUR OWN TRAINING  
25 PROGRAM THERE.

26 AND I SEE YOU HAVE A SEVERAL-VOLUME TEXT THERE ON  
27 PULMONARY PATHOLOGY. IF YOU RANDOMLY OPENED A PAGE, IT IS  
28 LIKELY THAT I SAW SOMEBODY WITH THAT DISEASE -- NOT

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1 EVERYBODY, BUT LIKELY -- BECAUSE THE REFERRAL POPULATION  
2 DURING THAT TWO YEARS WAS MORE THAN 5 MILLION PEOPLE.

3 IN A REFERRAL POPULATION OF MORE THAN 5 MILLION  
4 PEOPLE, EVEN UNUSUAL DISEASE APPEARS.

5 Q. SO IT'S BECAUSE THE PATIENTS WERE COMING FROM ALL  
6 OVER?

7 A. THEY WERE COMING FROM ALL OVER THE WORLD BECAUSE  
8 WE HAD AIR FORCE BASES ALL OVER THE WORLD.

9 Q. DID YOU TEND TO SEE THINGS THAT NORMALLY AREN'T  
10 SEEN IN EVERYDAY PRACTICE IN A HOSPITAL SETTING?

11 A. YES. I SAW A LOT OF VERY UNUSUAL DISEASE,  
12 BECAUSE THE REFERRAL POPULATION WAS SO LARGE.

13 IF SOMEONE HAD A SIMPLE-TO-DIAGNOSE-AND-TREAT  
14 DISEASE, THEY DIDN'T PUT THEM ON A PLANE AND MOVE THEM 7,000  
15 MILES. THEY TOOK CARE OF IT LOCALLY.

16 THE KINDS OF PROBLEMS THAT GOT REFERRED TO US  
17 WERE EITHER VERY DIFFICULT TO MANAGE OR PEOPLE WERE REFERRED  
18 TO US FOR DIAGNOSTIC EVALUATION.

19 Q. AND WHEN YOU GOT OUT OF THE AIR FORCE -- I TAKE  
20 YOU LEFT THERE?

21 A. I DID. AND I THEN CAME TO BERKELEY, WHERE I'VE  
22 BEEN IN THE PRIVATE PRACTICE OF PULMONARY DISEASES AND  
23 CRITICAL CARE EVER SINCE.

24 Q. NOW, IS ALTA BATES HOSPITAL A COMMUNITY-BASED  
25 HOSPITAL?

26 A. YES.

27 Q. AND YOU TREAT PEOPLE FROM ALL OVER THE BAY AREA?

28 A. YES. I WOULD SAY THE GREAT MAJORITY OF PEOPLE

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0005

1 THAT WE SEE ARE PEOPLE WHO LIVE NEARBY, WHO LIVE ON THE 880  
2 CORRIDOR FROM EL CERRITO DOWN TO HAYWARD THROUGH THE TUNNEL,  
3 MORAGA OR ORINDA, LAFAYETTE, WALNUT CREEK.

4 THAT IS WHERE THE BULK OF THE PEOPLE COME FROM.

5 BUT ALTA BATES HAS TERTIARY SERVICES, THAT IS --

6 Q. WHAT DOES THAT MEAN?  
7 A. THAT MEANS SERVICES THAT PEOPLE GET REFERRED INTO  
8 FOR CARE. SO PEOPLE COME FROM ELSEWHERE TOO.  
9 BUT THE GREAT MAJORITY OF PEOPLE ARE PEOPLE WHO  
10 LIVE IN THE COMMUNITY WE SERVE.  
11 Q. AND DO YOU HAVE BOARD CERTIFICATION IN ANY  
12 MEDICAL FIELDS?  
13 A. YES.  
14 Q. AND WHAT IS THAT?  
15 A. INTERNAL MEDICINE AND IN PULMONARY DISEASES.  
16 Q. AND PULMONARY DISEASES ARE LUNG DISEASES?  
17 A. RIGHT.  
18 Q. NOW, WHAT TITLES OR POSITIONS HAVE YOU HELD AT  
19 ALTA BATES HOSPITAL?  
20 A. A LOT. I HAVE OVER TIME BEEN ON A LOT OF  
21 DIFFERENT COMMITTEES AND CHAIRED MANY DIFFERENT COMMITTEES.  
22 FOR MANY YEARS, I WAS MEDICAL DIRECTOR OF  
23 UTILIZATION MANAGEMENT AT ALTA BATES.  
24 Q. WHAT IS THAT?  
25 A. THIS WAS AN APPOINTMENT, REALLY, THAT CAME FROM  
26 THE MEDICAL STAFF, ADDRESSING THE QUESTION: WHAT IS THE  
27 DEFINITION OF HIGH QUALITY, COST-EFFECTIVE CARE?  
28 AND AT A TIME WHEN RESOURCES AVAILABLE FOR  
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0006

1 MEDICINE ARE DECREASING, HOW DO WE DELIVER -- CONTINUE TO  
2 DELIVER THE HIGHEST QUALITY CARE, EVEN THOUGH THE MONEY  
3 AVAILABLE HAS BEEN GOING DOWN?  
4 SO I'VE BEEN REALLY FOR A PERIOD OF ABOUT 10  
5 YEARS WORKING WITH THE ENTIRE MEDICAL STAFF, ADDRESSING THE  
6 QUESTION WITHIN THEIR OWN INDIVIDUAL FIELDS: WHAT IS HIGH  
7 QUALITY, COST-EFFECTIVE CARE? AND HELPING THE MEDICAL STAFF  
8 DEFINE THAT AND DELIVER THAT KIND OF CARE.  
9 Q. IN THE COURSE OF DOING THAT, DID YOU HAVE TO LOOK  
10 AT WHAT DIFFERENT PROCEDURES OR SURGERIES COST?  
11 A. IN ORDER TO DEFINE THE COST SIDE OF THE EQUATION,  
12 I NEEDED TO LEARN ABOUT THE COSTS OF CARE. I KNOW MUCH MORE  
13 ABOUT THE COSTS OF CARE -- DELIVERING CARE THAN, YOU KNOW,  
14 MOST PHYSICIANS DO. I KNOW IT FOR OUR AREA, I KNOW IT FOR  
15 CALIFORNIA, I KNOW IT FOR A NUMBER OF PLACES IN THE UNITED  
16 STATES.  
17 I KNOW IT, BECAUSE IN ORDER TO DEFINE WHAT I  
18 NEEDED TO KNOW AS TO WHAT OUR COSTS WERE AND WHAT IT COST TO  
19 DELIVER CARE IN BROAD AREAS OF MEDICINE, I ALSO WANTED TO  
20 KNOW IF SOMEBODY ELSE DID IT BETTER.  
21 SO WERE THERE OTHER INSTITUTIONS THAT DID IT  
22 BETTER THAN WE DID, THAT THEY HAD THE SAME OUTCOME BUT WERE  
23 ABLE TO DO IT AT A CHEAPER PRICE?  
24 SO AS A RESULT, I LEARNED A LOT ABOUT THE COST OF  
25 CARE.  
26 Q. AND DO YOU HAVE ANY POSITIONS AT THE MOMENT AT  
27 THE HOSPITAL?  
28 A. WELL, ON JANUARY 1ST, I BECAME PRESIDENT OF THE  
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0007

1 MEDICAL STAFF AT ALTA BATES.  
2 Q. AND WHAT DOES THAT MEAN?  
3 A. WELL, COME BACK AND ASK ME THAT QUESTION IN ABOUT  
4 A YEAR. IT LOOKS TO ME LIKE IT'S ABOUT A 30 TO 40 HOUR A  
5 WEEK JOB.  
6 Q. IS THIS A JOB THAT YOU'RE GETTING EXTRA PAY FOR?  
7 A. I'M GETTING PAID, BUT I'M NOT GETTING PAID  
8 COMMENSURATE TO THE TIME THAT IT'S TAKING AND WHAT IMPACT IT

9 WILL HAVE ON MY LIFE.

10 THE MEDICAL STAFF IS RESPONSIBLE FOR THE QUALITY  
11 OF CARE AT ALTA BATES. WE'RE LICENSED -- THE PHYSICIANS ARE  
12 LICENSED BY THE STATE TO DELIVER CARE, AND REALLY, WE'RE THE  
13 ONLY ONES THAT CAN ASSESS THE QUALITY OF CARE. AND WE ARE  
14 FUNDAMENTALLY RESPONSIBLE FOR THE QUALITY OF CARE AT THE  
15 INSTITUTION.

16 SO I AM RESPONSIBLE FOR THIS RATHER ELABORATE  
17 PROCESS, ASSESSING THE QUALITY OF CARE AT THE INSTITUTION,  
18 BEING SURE THAT PHYSICIANS ARE PROPERLY CREDENTIALLED, MAKING  
19 SURE THAT, FROM THE STANDPOINT OF PHYSICIANS, WE MEET ALL OF  
20 THE REQUIREMENTS BY VARIOUS ACCREDITING AGENCIES, OF WHICH  
21 THERE IS A MYRIAD THAT COME THROUGH.

22 I'M RESPONSIBLE FOR PEER REVIEW ACTIVITIES. I  
23 DON'T DO THIS ALONE. OBVIOUSLY, A LOT OF THE MEDICAL STAFF  
24 ARE INVOLVED, BUT I'M RESPONSIBLE FOR THE PROCESS. IF  
25 SOMETHING GOES WRONG, THEORETICALLY, THE BUCK STOPS HERE,  
26 (INDICATING), AND IT'S MY RESPONSIBILITY TO INITIATE  
27 PROCESSES TO RESOLVE WHATEVER PROBLEMS THAT MIGHT OCCUR.

28 WE'RE RESPONSIBLE FOR PARTICIPATING IN THE  
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0008

1 ESTABLISHMENT OF NEW PROGRAMS FOR THE COMMUNITY, TO PROVIDE  
2 MEDICAL INPUT AND MAKE SURE THAT WE DELIVER QUALITY CARE.

3 Q. AND DO YOU DO THAT ROLE INSTEAD OF YOUR NORMAL  
4 PRACTICE?

5 A. WELL, I CLEARLY HAVE TO DECREASE THE AMOUNT OF  
6 TIME I'M SPENDING AT MY PRACTICE. THAT HAS TO SUBSTANTIALLY  
7 DECREASE. TO WHAT EXTENT IT WILL DECREASE IS NOT EVIDENT TO  
8 ME YET, BECAUSE IT'S NOT OBVIOUS TO ME YET HOW MUCH TIME  
9 THIS IS GOING TO TAKE OVER THE LONG HAUL.

10 THIS IS AT LEAST A HALF-TIME JOB, IF NOT MORE.  
11 SO OTHER COMPONENTS OF MY LIFE ARE GOING TO SUFFER  
12 SIGNIFICANTLY.

13 AND AT LEAST FOR THE NEXT TWO YEARS THAT I'M  
14 PRESIDENT, THE NUMBER OF PATIENTS I'M GOING TO TAKE CARE OF  
15 IS GOING TO GO DOWN SUBSTANTIALLY.

16 SO, FOR INSTANCE, IF SOMEBODY CALLS MY OFFICE TO  
17 SEE ME AS A NEW PATIENT, IT IS NOT GOING TO HAPPEN, BECAUSE  
18 THERE JUST SIMPLY ISN'T TIME TO DO IT, ALTHOUGH I WILL  
19 CONTINUE TO TAKE CARE OF THE PATIENTS THAT I'M CURRENTLY  
20 RESPONSIBLE FOR.

21 Q. AND DO YOU HAVE PARTNERS IN YOUR PULMONARY  
22 PRACTICE?

23 A. YES. THERE ARE FIVE OF US IN OUR PRACTICE.

24 Q. OKAY. AND ARE THERE TIMES WHEN YOU HAVE TO BE ON  
25 CALL OR ONE OF THEM HAS TO BE ON CALL?

26 A. WELL, I'M ON CALL. ONE THING THAT IS INVIOATE  
27 IS THAT I AM ON CALL, BECAUSE NONE OF MY PARTNERS HAVE  
28 VOLUNTEERED TO BE ON CALL FOR ME.

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1 SO ON AVERAGE, I'M ON CALL EVERY FIFTH DAY AND  
2 NIGHT. IT DOESN'T QUITE WORK OUT THAT WAY, BUT OVER THE  
3 YEAR, I AM ON CALL EVERY FIFTH DAY.

4 SO, FOR INSTANCE, I'M ON CALL TOMORROW FOR 24  
5 HOURS, AND THEN I'M ON CALL FOR THE ENTIRE WEEKEND FOR 48  
6 HOURS.

7 BUT I CONTINUE TO BE RESPONSIBLE FOR MY ON-CALL  
8 RESPONSIBILITIES. BUT ON OTHER DAYS, I'M CUTTING BACK ON  
9 WHAT I'VE BEEN DOING.

10 Q. OKAY. GIVE US AN IDEA WHAT YOU DO IN YOUR  
11 CLINICAL PRACTICE.

12 A. WELL, BEFORE JANUARY 1ST, I SPENT ABOUT HALF OF  
13 MY TIME IN CLINICAL PRACTICE, TAKING CARE OF PATIENTS IN THE  
14 CRITICAL CARE UNITS AND AROUND THE HOSPITAL.

15 WE HAVE A HOSPITAL-BASED PRACTICE, AND A LARGE  
16 PORTION OF WHAT WE DO IS TO TAKE CARE OF PEOPLE WHO ARE VERY  
17 SICK AT ALTA BATES, AND ALSO SEE OUTPATIENTS.

18 Q. AND YOUR OFFICE IS ACTUALLY IN THE HOSPITAL?

19 A. MY OFFICE IS IN THE HOSPITAL.

20 Q. IN TERMS OF THE TYPES OF ILLNESSES OR DISEASES  
21 YOU SEE, CAN YOU GIVE US AN IDEA WHAT YOU SEE IN YOUR  
22 CLINICAL PRACTICE?

23 A. WELL, THERE IS OUR CRITICAL CARE PRACTICE. WE  
24 SEE PEOPLE WHO ARE EXTREMELY SICK. MOST COMMONLY, THEY ARE  
25 IN RESPIRATORY FAILURE. THERE ARE ALL SORTS OF THINGS TO  
26 PRECIPITATE RESPIRATORY FAILURE.

27 ACTUALLY, WE TAKE CARE OF PEOPLE WHO ARE  
28 CRITICALLY ILL WITH PROBLEMS THAT HAVE NOTHING TO DO WITH

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0010

1 THE LUNG. FROM THE STANDPOINT OF THE LUNG, THE MOST COMMON  
2 DISEASES WE SEE ACTUALLY ARE CIGARETTE-RELATED DISEASES;  
3 THAT IS, INDIVIDUALS WHO HAVE CHRONIC BRONCHITIS AND/OR  
4 EMPHYSEMA, AND HAVE CIGARETTE-RELATED MALIGNANCIES, MOST  
5 COMMONLY LUNG CANCER. I WOULD SAY THAT IS WHAT WE SEE MOST  
6 COMMONLY.

7 WE SEE LOTS OF INDIVIDUALS WITH ASTHMA. THE  
8 PEOPLE WITH ASTHMA WHO GET TO US ARE PEOPLE WHO ARE QUITE  
9 SICK AND HAVE DIFFICULTY TO MANAGE THE DISEASE.

10 WE SEE LOTS OF PEOPLE WITH RESPIRATORY  
11 INFECTIONS, INCLUDING VARIETIES OF PNEUMONIA, OTHER KINDS OF  
12 RESPIRATORY INFECTIONS, AND AS WELL AS DISEASES THAT CAUSE  
13 INFLAMMATION IN THE LUNG.

14 Q. HAVE YOU OVER THE YEARS TAKEN AN INTEREST IN  
15 ASBESTOS?

16 A. YES.

17 Q. AND HOW DID THAT COME ABOUT?

18 A. WELL, IN 1977, TWO OF MY ASSOCIATES AND I  
19 EVALUATED ABOUT 350 WORKERS FROM THE MARE ISLAND NAVAL  
20 SHIPYARD IN VALLEJO AND PUBLISHED A PAPER REGARDING OUR  
21 EVALUATION OF THE SHIPYARD WORKERS.

22 I ALSO PRESENTED THE RESULTS OF OUR STUDY AT AN  
23 INTERNATIONAL SYMPOSIUM IN NEW YORK CITY, AND FROM THAT,  
24 FROM THAT WORK, THE U.S. DEPARTMENT OF LABOR WAS AWARE OF  
25 THE FACT THAT WE HAD BEEN STUDYING THEIR WORKERS AND BEGAN  
26 SENDING LARGE NUMBERS OF WORKERS TO ONE OF MY ASSOCIATES AND  
27 MYSELF TO EVALUATE FOR THE PURPOSE OF DETERMINING WHETHER  
28 THEY HAD WORK-RELATED DISEASE.

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1 ROUGHLY AT THE SAME TIME, I BEGAN SEEING WORKERS  
2 THROUGH THE STATE WORKERS' COMPENSATION SYSTEM; THAT IS,  
3 INSTEAD OF WORKING FOR THE FEDERAL GOVERNMENT, IF YOU WORK  
4 FOR A PRIVATE EMPLOYER IN THE STATE OF CALIFORNIA AND THERE  
5 IS SOME QUESTION AS TO WHETHER YOU HAVE A WORK-RELATED  
6 INJURY, THAT GETS EVALUATED THROUGH THE STATE WORKERS'  
7 COMPENSATION PROGRAM.

8 AND THERE ARE ATTORNEYS INVOLVED IN THAT SYSTEM.  
9 NOT THE FEDERAL SYSTEM, BUT IN THE STATE SYSTEM. PLAINTIFF  
10 ATTORNEYS AND DEFENSE ATTORNEYS BEGAN SENDING WORKERS TO ME  
11 TO EVALUATE. MANY OF THEM HAD ASBESTOS-RELATED DISEASE.

12 BUT I ALSO HAVE SEEN WORKERS WITH MANY OTHER  
13 KINDS OF WORK-RELATED ILLNESSES HAVING DO WITH THE LUNG.

14 Q. OVER TIME, HAVE YOU TESTIFIED OR BEEN ASKED TO

15 TESTIFY AS AN EXPERT WITNESS IN ASBESTOS CASES?  
16 A. YES.  
17 Q. AND THAT INCLUDES BY MY OFFICE?  
18 A. YES.  
19 Q. AND I TAKE IT WHEN YOU'RE HERE IN COURT, DOCTOR,  
20 AND NOT AT YOUR CLINICAL PRACTICE BACK AT THE HOSPITAL, YOU  
21 GET PAID FOR YOUR TIME HERE?  
22 A. I WILL CHARGE YOU FOR MY TIME HERE.  
23 Q. YOU'RE HOPING YOU'LL GET PAID?  
24 A. I WILL CERTAINLY HOPE I'LL GET PAID, YES.  
25 Q. AND IS THAT A STANDARD PRACTICE, AS FAR AS YOU'RE  
26 AWARE, OF DOCTORS TO BE PAID FOR THEIR TIME WHEN THEY COME  
27 TO COURT?  
28 A. SURE. BECAUSE I'M NOT IN MY OFFICE DOESN'T MEAN  
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1 THAT THE COSTS OF PRACTICE DON'T CONTINUE. THEY OBVIOUSLY  
2 CONTINUE; AN OFFICE FULL OF PEOPLE WHO NEED TO GET PAID.  
3 SO I CHARGE FOR MY TIME.  
4 Q. AND IF YOU'RE HERE, DO YOUR PARTNERS HAVE TO  
5 COVER SOME PORTION OF YOUR PRACTICE?  
6 A. OF COURSE.  
7 Q. AND THEY LIKEWISE TESTIFY?  
8 A. ONE OF MY PARTNERS TESTIFIES.  
9 Q. AND I TAKE IT HE CHARGES WHEN HE'S IN COURT?  
10 A. YES.  
11 Q. THE STUDY THAT YOU HAVE DONE OF THESE WORKERS,  
12 WAS THAT AN EPIDEMIOLOGIC STUDY?  
13 A. YES.  
14 Q. CAN YOU JUST EXPLAIN TO THE JURY A LITTLE BIT --  
15 THEY'VE HEARD SOMEWHAT ABOUT EPIDEMIOLOGY, BUT CAN YOU  
16 EXPLAIN A LITTLE BIT ABOUT WHAT YOU DID, HOW YOU WENT ABOUT  
17 IT.  
18 A. WE WERE INTERESTED IN DETERMINING WHETHER  
19 SHIPYARD WORKERS WERE AT RISK FOR ASBESTOS-RELATED DISEASE,  
20 AND TO WHAT EXTENT THEY WERE AT RISK FOR ASBESTOS-RELATED  
21 DISEASE.  
22 WE ALSO WANTED TO KNOW HOW IT RELATED TO THE  
23 SPECIFIC KIND OF WORK THAT THESE WORKERS DID; THAT IS, DID  
24 IT MATTER WHAT JOB YOU HAD AT THE SHIPYARD? WAS YOUR RISK  
25 FOR DEVELOPING AN ASBESTOS-RELATED DISEASE ANY DIFFERENT  
26 DEPENDING UPON WHAT KIND OF WORK YOU DID?  
27 SO WE EVALUATED A LARGE GROUP OF VOLUNTEERS WHO  
28 HAD CHEST X-RAYS. ACTUALLY, A LOT OF WORK WAS DONE, NOT ALL  
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1 OF WHICH WAS PUBLISHED. WE OBTAINED COMPLETE WORK HISTORIES  
2 OF ALL THEM SO WE COULD DELINEATE WHAT KIND OF WORK THAT  
3 THEY DID.  
4 WE KNEW HOW LONG THEY HAD WORKED AT THE SHIPYARD,  
5 WHEN THEY HAD STARTED WORKING, AND WE WERE INTERESTED IN  
6 DETERMINING HOW MANY HAD ASBESTOS-RELATED DISEASE.  
7 Q. AND WHAT DID YOU CONCLUDE, JUST BRIEFLY, IN THAT  
8 STUDY?  
9 A. A LARGE PORTION HAD ASBESTOS-RELATED DISEASE. I  
10 DETERMINED IT DIDN'T MATTER WHAT YOU DID IN THE SHIPYARD.  
11 IF YOU WORKED IN THE INTERIORS OF SHIPS WHERE  
12 ASBESTOS-CONTAINING PRODUCTS WERE BEING HANDLED, YOU WERE AT  
13 ROUGHLY EQUAL RISK FOR DEVELOPING ASBESTOS-RELATED DISEASE,  
14 NO MATTER WHETHER YOU WERE ONE OF THE INDIVIDUALS ACTUALLY  
15 HANDLING ASBESTOS OR YOU WERE WHAT'S CALLED A BYSTANDER;  
16 THAT IS, SOMEBODY WHO IS WORKING IN THE SAME AREA WHERE  
17 ASBESTOS-CONTAINING PRODUCTS WERE BEING HANDLED BUT YOU

18 DIDN'T DO IT YOURSELF.  
19 Q. AND YOU SAID YOU PRESENTED THAT AT A SYMPOSIUM.  
20 WAS THAT A PRESTIGIOUS THING TO DO, TO PRESENT  
21 THAT AT THIS SYMPOSIUM?  
22 A. YEAH. THE STRAIGHT ANSWER IS YEAH. ACTUALLY, IT  
23 WAS AN EXTREMELY IMPORTANT CONFERENCE. REALLY, EVERYONE  
24 IMPORTANT WHO HAD INTEREST IN ASBESTOS-RELATED DISEASE FROM  
25 ALL OVER THE WORLD WAS AT THAT CONFERENCE, AND A LOT OF VERY  
26 IMPORTANT PAPERS WERE PRESENTED AT THAT CONFERENCE.  
27 Q. OKAY.  
28 A. AND SUBSEQUENTLY PUBLISHED.  
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0014

1 Q. AND THAT WAS BACK IN 1979?  
2 A. 1978, SUMMER OF 1978.  
3 Q. AND SINCE THEN, YOU CONTINUE TO SEE PEOPLE WITH  
4 ASBESTOS DISEASE?  
5 A. I HAVE SEEN AN ENORMOUS NUMBER.  
6 Q. AND HAVE YOU SEEN THEM IN YOUR CLINICAL PRACTICE  
7 AS WELL AS THROUGH THE COMPENSATION SYSTEMS?  
8 A. YES. BECAUSE OF WHERE I AM IN PRACTICE, THERE  
9 ARE A LOT OF PEOPLE WHO LIVE IN THE AREA THAT ARE SERVED BY  
10 ALTA BATES WHO HAVE BEEN OCCUPATIONALLY EXPOSED TO ASBESTOS  
11 IN THE PAST. AND WE HAVE SEEN A LOT OF PEOPLE IN OUR  
12 PRACTICE WHERE WE HAVE DIAGNOSED THEM AS HAVING  
13 ASBESTOS-RELATED DISEASE.  
14 Q. EARLIER, YOU HAD INDICATED THAT MOST OF THE  
15 PEOPLE YOU SEE HAVE CIGARETTE-RELATED DISEASE?  
16 A. YES. IN MY CLINICAL PRACTICE, YOU KNOW, IF I  
17 WERE TO PICK ONE THING OUT OF MY CLINICAL PRACTICE AS A  
18 MARKER OF DISEASE THAT I SEE MOST OFTEN, IT WOULD BE  
19 CIGARETTE-RELATED DISEASE.  
20 IN MY MEDICAL/LEGAL PRACTICE, IT'S  
21 ASBESTOS-RELATED DISEASE.  
22 Q. AND IN TERMS OF CIGARETTE-RELATED DISEASE, TELL  
23 US WHAT TYPES OF DISEASE YOU HAVE SEEN THAT ARE CAUSED BY  
24 CIGARETTES.  
25 A. YOU COULD DIVIDE CIGARETTE-RELATED DISEASES INTO  
26 THREE MAJOR CATEGORIES. THERE IS NONMALIGNANT LUNG DISEASE;  
27 THAT IS, CHRONIC BRONCHITIS AND EMPHYSEMA.  
28 THERE'S MALIGNANT DISEASE, WHICH INCLUDES CANCER  
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0015

1 OF THE LUNG AND OTHER MALIGNANCIES IN THE BODY.  
2 AND THERE IS HEART DISEASE. CLEARLY, CIGARETTE  
3 SMOKING CAUSES HEART DISEASE.  
4 Q. NOW, IN TERMS OF MS. HENLEY'S CASE -- ACTUALLY,  
5 BEFORE I GO THERE, WHEN YOU'RE SEEING A PATIENT, WHETHER  
6 IT'S FOR LEGAL PURPOSES OR AS PART OF YOUR CLINICAL  
7 PRACTICE, ARE THERE THINGS THAT YOU STANDARDLY DO IN ORDER  
8 TO EVALUATE THE PERSON?  
9 A. YES.  
10 Q. AND CAN YOU TELL US WHAT THOSE ARE.  
11 A. I GET A HISTORY OF WHAT BOTHERS THE PERSON, WHY  
12 THEY'RE COMING TO SEE ME, WHAT ARE THE ISSUES.  
13 I ASK ABOUT A WHOLE VARIETY OF KINDS OF PROBLEMS  
14 THAT PEOPLE WITH LUNG DISEASE MIGHT HAVE. I WANT TO KNOW  
15 WHAT PRIOR MEDICAL OR SURGICAL PROBLEMS AN INDIVIDUAL HAD  
16 AND, YOU KNOW, WHAT DIAGNOSES WERE MADE, HOW WERE THEY  
17 TREATED. I WANT TO KNOW WHAT KIND OF MEDICATIONS THEY WERE  
18 ON.  
19 I WILL TYPICALLY GO THROUGH WHAT'S CALLED A  
20 REVIEW OF SYSTEMS.

21 Q. WHAT'S THAT?  
22 A. THAT IS, I WILL -- I WILL LOOK FOR PROBLEMS THAT  
23 PEOPLE MIGHT NOT REMEMBER TO TELL ME. SO IF THEY DON'T TELL  
24 ME ABOUT HEART DISEASE, I WILL SPECIFICALLY ASK THEM ABOUT  
25 HEART DISEASE. I'LL ASK THEM WHETHER THEY HAVE ANY  
26 DIFFICULTIES INVOLVING THE GASTROINTESTINAL TRACT. I'LL ASK  
27 THEM ABOUT PROBLEMS RELATED TO THE KIDNEYS OR BLADDER. I  
28 WILL ASK THEM ABOUT ANY NEUROLOGIC DISEASE. I'LL ASK THEM  
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0016

1 ABOUT MUSCULAR DISEASE. I WILL ASK THEM ABOUT ARTHRITIS.  
2 I'LL ASK THEM ABOUT WHAT MEDICATIONS THEY'RE ON.  
3 WHENEVER I EVALUATE ANYBODY, I GET A WORK  
4 HISTORY, ALTHOUGH IF I'M SEEING THEM FOR MEDICAL/LEGAL  
5 PURPOSES, MY WORK HISTORY TENDS TO BE MUCH MORE DETAILED  
6 THAN IT IS IN MY NORMAL PRACTICE, MY CLINICAL PRACTICE, BUT  
7 I ALWAYS ASK THEM THAT.  
8 Q. WHY DO YOU ASK FOR A WORK HISTORY REGARDLESS OF  
9 WHETHER IT'S FOR A LEGAL SITUATION OR A CLINICAL SITUATION?  
10 A. BECAUSE IT MAY BE RELEVANT TO A PROBLEM I'M  
11 EVALUATING THEM FOR. PEOPLE USUALLY ARE REFERRED TO ME  
12 BECAUSE THEY ARE THOUGHT TO HAVE A RESPIRATORY PROBLEM, AND  
13 THAT'S ALWAYS IN THE DIFFERENTIAL DIAGNOSIS, WHETHER THEY  
14 HAVE A WORK-RELATED ILLNESS.  
15 AND I ALSO PUT SOME THINGS IN RECORDS, SO IT'S  
16 AVAILABLE AT A FUTURE TIME FOR EITHER MYSELF OR OTHERS IN  
17 THE FUTURE. IT MIGHT BE RELEVANT INFORMATION FOR PEOPLE TO  
18 HAVE.  
19 I DO A PHYSICAL EXAMINATION. THAT'S A COMPLETE  
20 PHYSICAL EXAMINATION OF INDIVIDUALS. I'LL ORDER -- I MAY OR  
21 MAY NOT ORDER TESTS, DEPENDING UPON WHETHER THEY'RE RELEVANT  
22 TO DO OR NOT. AND I'LL SUMMARIZE MY CONCLUSIONS.  
23 Q. DO YOU ALSO, TO THE EXTENT POSSIBLE, REVIEW  
24 MEDICAL RECORDS?  
25 A. IF THEY'RE AVAILABLE, SURE.  
26 Q. ARE THERE CERTAIN SYMPTOMS THAT, WHEN YOU HEAR  
27 THESE SYMPTOMS IN AN INDIVIDUAL THAT'S COME TO YOU FOR  
28 RESPIRATORY PROBLEMS, THAT LEADS YOU TO START THINKING ABOUT  
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0017

1 SUSPECTED LUNG CANCER?  
2 A. INDIVIDUALS WITH LUNG CANCER COMMONLY PRESENT  
3 WITH SYMPTOMS SUCH AS COUGH, CHEST PAIN, SHOULDER PAIN,  
4 SHORTNESS OF BREATH, SPUTUM PRODUCTION, COUGHING UP BLOOD,  
5 SOMETIMES WHEEZING, WEAKNESS, WEIGHT LOSS, LOSS OF APPETITE,  
6 JUST SORT OF FEELING LIKE THE BLAHS.  
7 THAT ISN'T TO SAY THAT EVERYBODY PRESENTS WITH  
8 ALL OF THESE SYMPTOMS. MOST PEOPLE PRESENT WITH AT LEAST  
9 SOME OF THESE SYMPTOMS.  
10 Q. IF AN INDIVIDUAL COMES TO YOU WITH SOME KIND OF A  
11 RESPIRATORY PROBLEM AND TELLS YOU THAT THEY'RE COUGHING UP  
12 BLOOD OR BLOOD-TINGED SPUTUM, DOES THAT TRIGGER ANY CONCERNS  
13 ABOUT CANCER?  
14 A. CANCER INVOLVING THE AIRWAY WOULD ALWAYS BE -- OR  
15 ALMOST ALWAYS WOULD BE IN THE DIFFERENTIAL DIAGNOSIS.  
16 Q. NOW, ARE THERE PARTICULAR TESTS THAT YOU  
17 RECOMMEND IN TRYING TO DETERMINE OR DO A WORK-UP FOR LUNG  
18 CANCER?  
19 A. WHERE I CONSIDER IT A POSSIBILITY?  
20 Q. YES.  
21 A. WELL, RIGHT OFF -- ALL RIGHT. SO I -- LET ME SEE  
22 IF I'VE GOT THE QUESTION RIGHT.  
23 I'M SEEING SOMEBODY. THEY GIVE ME A HISTORY OF

24       WHATEVER THEIR COMPLAINTS ARE.  
25               AND AS PART OF MY EVALUATION, I SAY, "AHA, LUNG  
26       CANCER." I HAVE TO CONSIDER WHETHER THIS INDIVIDUAL HAS  
27       LUNG CANCER?  
28       Q.     RIGHT.

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0018

1       A.     OKAY.  
2       Q.     WHAT DO YOU DO NEXT?  
3       A.     THE FIRST THING IS, THEY GET A SET OF CHEST  
4       X-RAYS. AND DEPENDING UPON WHAT THE X-RAYS SHOW, I PROCEED  
5       FROM THERE.  
6               TYPICALLY, FROM THERE, I WOULD GET, IF THE X-RAY  
7       IS ABNORMAL -- MAYBE EVEN IF THE X-RAY IS NOT ABNORMAL, I  
8       WOULD PROBABLY GO ON AND GET A CT SCAN OF THE CHEST TO  
9       DELINEATE THE EXTENT OF ABNORMALITIES IN THE CHEST.  
10       AND AT THAT POINT, IT WOULD DEPEND UPON WHAT  
11       INFORMATION I HAVE AVAILABLE AS TO WHAT I WOULD DO. BECAUSE  
12       IF I CONSIDER THAT -- IF I'M CONSIDERING THAT AN INDIVIDUAL  
13       HAS LUNG CANCER, AND AT THIS POINT I HAVE POSITIVE FINDINGS  
14       AND THAT I'M SERIOUSLY CONSIDERING THAT IS THE DIAGNOSIS,  
15       THEN I NEED A TISSUE DIAGNOSIS.  
16       AND HOW I GET IT, A TISSUE DIAGNOSIS, DEPENDS  
17       UPON THE CLINICAL PRESENTATION AS TO WHAT'S DONE NEXT.  
18       Q.     OKAY. AND CAN YOU GIVE US AN IDEA OF WHAT WAYS  
19       THERE ARE TO GET A CLINICAL TISSUE DIAGNOSIS.  
20       A.     WELL, THERE ARE SEVERAL WAYS. ONE WAY  
21       POTENTIALLY IS TO BRONCHOSCOPE PATIENTS. A BRONCHOSCOPE IS  
22       AN INSTRUMENT WHICH IS ABOUT THE DIAMETER OF MY PEN AND IT'S  
23       ABOUT THAT LONG (INDICATING), AND IT BENDS. YOU CAN BEND IT  
24       INTO A CURLICUE. IT'S FLEXIBLE.  
25       AND IN THIS INSTRUMENT, WHICH IS ABOUT THAT LONG  
26       (INDICATING), THERE ARE ABOUT 1,000 VERY, VERY TINY GLASS  
27       FIBERS, EXTREMELY THIN FIBERS. THEY'RE CALLED FIBEROPTIC  
28       CABLES. AND THESE THIN FIBERS CAN BEND. AND THERE'S A

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0019

1       LIGHT SOURCE ON THIS THING.  
2       SO WHAT YOU COULD DO IS, IF I HAVE IT IN MY HAND,  
3       I COULD BEND IT LIKE A PRETZEL AND AIM AT THE CEILING AND  
4       LOOK IN ONE END AND I CAN SEE THE CEILING. SO IT'S YOUR  
5       ULTIMATE PERISCOPE THAT CAN SEE AROUND CORNERS.  
6       SO WHAT WE TYPICALLY DO IN PATIENTS IS WE NUMB UP  
7       INDIVIDUALS' NOSES AND THE BACK OF THEIR THROAT SO THEY  
8       DON'T FEEL ANYTHING, CAN'T FEEL ANYTHING AT ALL. WE TAKE  
9       AWAY ALL SENSATION. AND OFTEN WE SEDATE PEOPLE. SOMETIMES  
10       WE CAN'T.  
11       THEN THE INSTRUMENT GOES THROUGH THE NOSE,  
12       THROUGH THE BACK OF THE THROAT, THROUGH THE VOCAL CORDS,  
13       DOWN THE TRACHEA (INDICATING), DOWN IN THE AIRWAY.  
14       AND YOU CAN CONTROL THE END OF THIS INSTRUMENT.  
15       YOU CAN AIM IT WHERE YOU WANT TO GO, AND YOU CAN SEE WHERE  
16       YOU'RE GOING IN THERE, IN THE AIRWAY. SO YOU CAN LOOK  
17       AROUND THE LARGER AIRWAYS TO LOOK FOR AN ABNORMALITY.  
18       AND IF YOU FIND AN ABNORMALITY, THERE'S A  
19       LITTLE -- A TWO-MILLIMETER CHANNEL GOES THROUGH THE ENTIRE  
20       LENGTH OF THIS INSTRUMENT. YOU CAN PUT VARIOUS INSTRUMENTS  
21       THROUGH THIS TWO MILLIMETER CHANNEL -- TWO MILLIMETERS IS  
22       VERY, VERY THIN -- AND GET SPECIMENS FROM INSIDE THE LUNG.  
23       ACTUALLY, IT DOESN'T HURT. THERE ARE NO PAIN  
24       FIBERS INSIDE THE LUNG, SO IT DOESN'T HURT TO GET TISSUE  
25       FROM THE LUNG. SO THAT'S ONE WAY TO MAKE A DIAGNOSIS.  
26       IF THE LESION OCCURS IN THE LUNG OUT DISTALLY,

27 WHERE YOU CAN'T GET TO IT VERY EASILY WITH --  
28 Q. DISTALLY?

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0020

1 A. OUT AT THE END OF THE LUNG.

2 Q. THANK YOU.

3 A. -- WHERE YOU CAN'T REACH IT WITH A BRONCHOSCOPE,  
4 SO THEN WHAT YOU MIGHT DO IS PUT A NEEDLE -- FROM THE  
5 OUTSIDE, YOU NUMB UP THE SKIN AND THE TISSUE UNDER THE SKIN,  
6 AND YOU PUT A NEEDLE FROM THE OUTSIDE INTO THE LESION.  
7 THAT'S ANOTHER POSSIBILITY.

8 A THIRD POSSIBILITY IS TO GET TISSUE FROM THE  
9 MIDDLE OF THE CHEST (INDICATING). CANCERS OF THE LUNG  
10 COMMONLY SPREAD TO INVOLVE THE LYMPH NODES THAT ARE IN THE  
11 MIDDLE OF THE CHEST. SO YOU MIGHT DO A PROCEDURE WHERE YOU  
12 MAKE A SMALL INCISION IN THE NECK, ABOVE THE STERNUM HERE  
13 (INDICATING), AND YOU PUT -- THIS IS DONE UNDER GENERAL  
14 ANESTHESIA -- YOU PUT AN INSTRUMENT UNDERNEATH THE STERNUM  
15 TO GET AT THE LYMPH NODES IN THE MIDDLE OF THE CHEST.

16 OR ANOTHER WAY YOU CAN GET AT THESE LITTLE --  
17 THESE LYMPH NODES, AGAIN UNDER GENERAL ANESTHESIA, IS TO  
18 MAKE A SMALL INCISION IN THE CHEST WALL (INDICATING) ON  
19 EITHER SIDE OF THE STERNUM OR THE BREAST BONE TO GET DOWN AT  
20 THE LYMPH NODES.

21 AND LASTLY, IF NECESSARY, A SURGEON MIGHT DO AN  
22 OPERATION TO GET INTO THE CHEST TO MAKE A DIAGNOSIS; THAT  
23 IS, AN INCISION IS MADE BETWEEN THE RIBS TO GET INTO THE  
24 CHEST TO GET TO THE LUNG TO MAKE A DIAGNOSIS, AND MAYBE  
25 POTENTIALLY TREAT SOMEBODY, DEPENDING UPON HOW THEY PRESENT.

26 Q. NOW, OF THE THINGS THAT YOU'VE JUST DESCRIBED,  
27 ARE THERE ANY THAT YOU DO YOURSELF?

28 A. I BRONCHOSCOPE PATIENTS.

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0021

1 Q. IS THAT SOMETHING YOU HAVE BEEN DOING FOR YEARS?

2 A. SINCE 1974.

3 Q. YOU WERE ASKED TO EVALUATE PATRICIA HENLEY?

4 A. YES.

5 Q. DID YOU SEE AND EXAMINE PATRICIA HENLEY?

6 A. YES.

7 Q. CAN YOU TELL US THE NATURE OF YOUR EXAMINATION OF  
8 PATRICIA HENLEY.

9 A. I SAW HER IN AUGUST OF 1998. I GOT A HISTORY  
10 FROM HER IN TERMS OF WHAT HAD HAPPENED TO HER. I ALSO GOT A  
11 WORK HISTORY FROM HER. I GOT A PAST MEDICAL HISTORY FROM  
12 HER.

13 I DID A REVIEW OF SYSTEMS, AS I DESCRIBED IT. I  
14 GOT A FAMILY HISTORY FROM HER. I DID A PHYSICAL  
15 EXAMINATION. SHE HAD LUNG FUNCTION TESTS DONE IN OUR  
16 LABORATORY AT ALTA BATES.

17 Q. WE'LL COME BACK TO THAT IN A FEW MINUTES. GO  
18 ON.

19 A. SHE HAD CHEST X-RAYS DONE AT ALTA BATES. YOUR  
20 OFFICE PROVIDED ME WITH MEDICAL RECORDS TO REVIEW, AND I  
21 REVIEWED THOSE MEDICAL RECORDS.

22 AND I ALSO REVIEWED X-RAYS THAT WERE SENT TO ME  
23 THAT HAD BEEN DONE PREVIOUSLY, AND I WROTE A REPORT AND SENT  
24 IT TO YOU.

25 Q. IN TERMS OF YOUR EXAMINING AND TALKING TO  
26 MS. HENLEY, TELL ME HOW THAT WENT, HOW YOU WENT ABOUT THE  
27 ACTUAL INTERVIEWING OF HER.

28 A. WELL, WHAT I TRY TO DO IS DO AN OPEN-ENDED

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0022

1 INTERVIEW, SO THAT I DON'T SUGGEST THINGS. I ASK PEOPLE  
2 WHAT'S WRONG WITH THEM. AND THEN SHE TOLD ME WHAT WAS WRONG  
3 WITH HER.

4 AND I SAID: "AND WHAT HAPPENED? WHAT LED TO THE  
5 DIAGNOSIS BEING MADE?"

6 SO WE WENT THROUGH THE SEQUENCE OF WHAT HAPPENED  
7 LEADING TO THE DIAGNOSIS OF LUNG CANCER.

8 Q. AND YOU SAID YOU TOOK A WORK HISTORY?

9 A. I DID, FROM HER.

10 Q. AND WHAT WORK HISTORY DID YOU GET FROM HER?

11 A. NONE OF IT IS RELEVANT. SHE SOLD MAGAZINES, SHE  
12 WORKED AS A WAITRESS. IN THE LATE 1960S, SHE WORKED FOR A  
13 ROTO-ROOTER KIND OF COMPANY, AND THEN, ACTUALLY SUBSEQUENTLY  
14 OWNED SUCH A COMPANY.

15 SHE HAS ALSO BEEN A SINGER, AT LEAST UP UNTIL  
16 LAST YEAR, ON A PART-TIME BASIS. SHE WORKS AS A BOOKKEEPER.

17 Q. NOW, YOU SAID "NONE OF WHICH WAS RELEVANT."

18 WHAT DID YOU MEAN BY THAT?

19 A. IF I SEE SOMEBODY WHO I'VE DIAGNOSED AS HAVING  
20 LUNG CANCER, A QUESTION I WOULD ALWAYS ASK IS: HAS THIS  
21 INDIVIDUAL BEEN EXPOSED TO ANY CHEMICAL CARCINOGENS? SO  
22 THAT WOULD INCLUDE CIGARETTE SMOKING. IT ALSO WOULD INCLUDE  
23 A NUMBER OF INDUSTRIAL ENVIRONMENTS WHERE PEOPLE CAN BE  
24 EXPOSED TO CHEMICAL CARCINOGENS.

25 Q. AND DID YOU GET ANY HISTORY OF EXPOSURE TO  
26 CHEMICAL CARCINOGENS OTHER THAN CIGARETTE SMOKE?

27 A. NO.

28 Q. DO YOU TAKE A SMOKING HISTORY OF YOUR PATIENTS  
JUDITH ANN OSSA, CSR NO. 2310

0023

1 THAT YOU SEE IN YOUR CLINICAL PRACTICE?

2 A. EVERYONE.

3 Q. AND WHY IS THAT?

4 A. BECAUSE SMOKING-RELATED DISEASE IS SUCH A  
5 PREVALENT PART OF MY PRACTICE, I ALWAYS ASK ABOUT CIGARETTE  
6 SMOKING.

7 Q. AND WHAT TYPE OF SMOKING HISTORY DO YOU TAKE? DO  
8 YOU JUST SAY: "DID YOU SMOKE CIGARETTES," THEY SAY YES, AND  
9 THAT'S THE END OF IT?

10 A. NO. I TRY TO QUANTITATE WHAT PEOPLE HAVE SMOKED,  
11 WHEN THEY STARTED, WHEN THEY STOPPED, IF THEY IN FACT  
12 STOPPED, AND HOW MUCH THEY SMOKED.

13 Q. AND WHAT HISTORY DID YOU OBTAIN FROM MS. HENLEY  
14 WITH RESPECT TO HER SMOKING?

15 A. MR. HENLEY INDICATED THAT SHE BEGAN SMOKING AT  
16 AGE 15 AND THEN CONTINUED TO SMOKE FROM THEN UNTIL OCTOBER  
17 1997. SHE AVERAGED ABOUT TWO PACKS OF CIGARETTES PER DAY UP  
18 UNTIL AGE 43.

19 WHEN I SAW HER, SHE WAS 51. BETWEEN AGES 43 AND  
20 51, SHE SMOKED ABOUT THREE AND A HALF PACKS OF CIGARETTES  
21 PER DAY.

22 Q. AND DOES THAT SMOKING HISTORY FIGURE IN ANY WAY  
23 IN YOUR OPINIONS WITH RESPECT TO MS. HENLEY?

24 A. SURE.

25 Q. FIRST OF ALL, LET ME ASK YOU A BASIC QUESTION:  
26 DOES CIGARETTE SMOKING CAUSE ANY DISEASES?

27 A. YES.

28 Q. WHAT DISEASES DOES CIGARETTE SMOKING CAUSE?  
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0024

1 A. WELL, AS I POINTED OUT BEFORE, CIGARETTE SMOKING  
2 CLEARLY CAUSES NONMALIGNANT LUNG DISEASE, CHRONIC BRONCHITIS

3 AND EMPHYSEMA. CIGARETTE SMOKING UNQUESTIONABLY CAUSES A  
4 VARIETY OF MALIGNANCIES. WITHOUT QUESTION, LUNG CANCER IS  
5 THE MOST COMMON.

6 CIGARETTE SMOKING ALSO CAUSES HEART DISEASE.

7 Q. DID YOU DETERMINE WHETHER OR NOT PATRICIA HENLEY  
8 HAD ANY CIGARETTE-RELATED DISEASE?

9 A. SHE DID. WELL, SHE DOES. SHE ACTUALLY HAS  
10 SEVERAL.

11 Q. OKAY. AND CAN YOU FIRST INDICATE WHAT DISEASES  
12 SHE HAS CAUSED BY CIGARETTE SMOKING, AND THEN WE CAN TALK  
13 MORE SPECIFICALLY ABOUT THEM.

14 A. SHE HAS SMALL CELL CARCINOMA OF THE LUNG,  
15 UNQUESTIONABLY CAUSED BY HER HISTORY OF CIGARETTE SMOKING.  
16 SHE ALSO HAS CHRONIC OBSTRUCTIVE PULMONARY  
17 DISEASE, A GOOD DEAL OF WHICH IS EMPHYSEMA, CLEARLY CAUSED  
18 BY CIGARETTE SMOKING.

19 Q. ALL RIGHT. LET'S START WITH THE EMPHYSEMA.  
20 MR. OHLEMEYER: EXCUSE ME, YOUR HONOR. I OBJECT  
21 TO THIS ON THE BASIS OF RELEVANCE.

22 THE CLAIM IN THIS CASE IS LUNG CANCER.

23 MS. CHABER: THE CLAIM IN THIS CASE IS INJURY.

24 THE COURT: COUNSEL, I DON'T WANT ARGUMENT IN  
25 FRONT OF THE JURY. YOU KNOW THAT. I TOLD YOU BOTH THAT  
26 FROM THE OUTSET OF THE CASE.

27 WE CAN HAVE A VERY BRIEF SIDEBAR AND DISCUSS  
28 THIS, IF YOU WANT. SO LET'S JUST TAKE ONE.

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0025

1 MS. CHABER: OKAY.

2 (COURT AND COUNSEL CONFER OUTSIDE  
3 THE PRESENCE OF THE JURY)

4 THE COURT: OKAY. WE'RE BACK ON THE RECORD.

5 MS. CHABER: OKAY. I'M GOING TO WITHDRAW THAT  
6 QUESTION WITHOUT PREJUDICE, BUT FOR THE MOMENT.

7 THE COURT: THAT'S FINE.

8 MS. CHABER: Q. DR. HORN, WHEN YOU EXAMINED  
9 MS. HENLEY, TOOK A SMOKING HISTORY FROM HER, REVIEWED HER  
10 CHEST X-RAYS AND CT SCANS, REVIEWED HER MEDICAL RECORDS, DID  
11 YOU CONCLUDE WHETHER OR NOT SHE HAD A CANCER CAUSED BY  
12 CIGARETTE SMOKING?

13 A. YES.

14 Q. AND CAN YOU TELL US HOW YOU CAME TO THAT  
15 CONCLUSION.

16 A. I HAD AN OPPORTUNITY TO GET A HISTORY FROM HER.  
17 I REVIEWED HER RECORDS, WHICH SUPPORT THAT HISTORY. I  
18 REVIEWED THE RECORDS OF THE TREATING PHYSICIANS, INCLUDING  
19 HER ONCOLOGIST AND HER TREATMENT AT USC, L.A. COUNTY.

20 I AM AWARE OF THE RESULTS OF THE PATHOLOGY  
21 REPORT. THE PATHOLOGY HAS BEEN INDEPENDENTLY LOOKED AT BY  
22 ANOTHER PATHOLOGIST, AND I HAVE REVIEWED THAT REPORT.

23 Q. THAT WAS DR. HAMMAR?

24 A. DR. HAMMAR.

25 I HAVE REVIEWED THE X-RAY REPORTS, AND HAVE HAD  
26 AN OPPORTUNITY TO REVIEW HER X-RAYS AND KNOW ABOUT HER  
27 CLINICAL COURSE.

28 AND PUTTING ALL OF THAT INFORMATION TOGETHER, I  
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0026

1 HAVE CONCLUDED THAT MS. HENLEY HAS SMALL CELL CANCER OF THE  
2 LUNG.

3 Q. AND WHAT IS THE BASIS OF HOW YOU CAME TO THAT  
4 CONCLUSION?

5 A. SHE PRESENTED TYPICALLY. SHE COMPLAINED OVER A

6 PROLONGED PERIOD OF TIME OF SOME INCREASED COUGH AND SPUTUM  
7 PRODUCTION. SHE DEVELOPED HOARSENESS. SHE THEN DEVELOPED  
8 INCREASING COUGH AND SHORTNESS OF BREATH AND BEGAN COUGHING  
9 UP BLOOD. AND BECAUSE OF THAT, SHE WAS INITIALLY  
10 EVALUATED.

11 THE PHYSICIAN WHO INITIALLY SAW HER THOUGHT THAT  
12 SHE MIGHT HAVE HAD A RESPIRATORY INFECTION AND PUT HER ON  
13 ANTIBIOTICS, BUT SHE HAD PERSISTENT SYMPTOMS.

14 A CHEST X-RAY WAS PERFORMED, WHICH WAS ABNORMAL,  
15 AND THEN SHE WAS REFERRED TO A PULMONARY SPECIALIST FOR  
16 EVALUATION, WHO WAS CONCERNED THAT SHE HAD LUNG CANCER.

17 SHE WAS SUBSEQUENTLY REFERRED TO L.A. COUNTY/USC,  
18 WHERE SHE WAS HOSPITALIZED. AND A PROCEDURE CALLED A  
19 MEDIASTINOTOMY WAS PERFORMED. AND SHE WAS DIAGNOSED AS  
20 HAVING SMALL CELL CARCINOMA OF THE LUNG.

21 SHE SUBSEQUENTLY WAS REFERRED TO AN ONCOLOGIST IN  
22 BURBANK, WHO CONFIRMED AND AGREED WITH THE DIAGNOSIS AND  
23 SUBSEQUENTLY TREATED HER.

24 AND HER TREATMENT HAS BEEN THAT OF SOMEONE WHO  
25 HAS SMALL CELL CARCINOMA. AND HER COURSE IS PRETTY TYPICAL  
26 OF SOMEONE WITH SMALL CELL CARCINOMA OF THE LUNG.

27 Q. NOW, WHEN YOU SAY "HER COURSE HAS BEEN TYPICAL  
28 WITH SOMEONE WITH SMALL CELL CARCINOMA OF THE LUNG," CAN YOU

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0027

1 DEMONSTRATE THAT BY X-RAY, CT SCAN OR OTHER MEANS?

2 A. BOTH BY X-RAY AND CT SCAN. SHE HAS CLEARLY  
3 RESPONDED INITIALLY TO CHEMOTHERAPY, AND THE ORIGINAL  
4 LESION, WHICH WAS QUITE LARGE, JUST SORT OF MAGICALLY  
5 DISAPPEARED.

6 BUT WE KNOW, BOTH IN HER AND BECAUSE OF PRIOR  
7 EXPERIENCE WITH MANY, MANY OTHER INDIVIDUALS WITH SMALL CELL  
8 CARCINOMA, THAT IT'S MISLEADING, THAT THE DISEASE WILL  
9 RECUR, AND IT'S PROBABLY REOCCURRING NOW. AND SHE WILL DIE  
10 OF THIS MALIGNANCY.

11 Q. NOW, IN TERMS OF YOUR DETERMINATION THAT SHE HAD  
12 SMALL CELL CARCINOMA OF THE LUNG, FIRST OF ALL, HAVE YOU  
13 DIAGNOSED PEOPLE IN YOUR CLINICAL PRACTICE WITH SMALL CELL  
14 CARCINOMA OF THE LUNG?

15 A. A VERY LARGE NUMBER. OVER THE LAST -- WELL,  
16 SINCE THE BEGINNING OF MY TRAINING IN PULMONARY DISEASE IN  
17 1971, PROBABLY EARLIER THAN THAT TOO, BUT REALLY WHEN I  
18 BEGAN MY TRAINING IN PULMONARY DISEASE, SINCE 1971, IN THAT  
19 ALMOST 28-YEAR PERIOD, I'VE SEEN AN ENORMOUS NUMBER OF  
20 PEOPLE WITH SMALL CELL CARCINOMA OF THE LUNG.

21 Q. AND IS MS. HENLEY'S PRESENTATION HIGHLY UNUSUAL  
22 FOR SOMEONE WITH SMALL CELL CARCINOMA OF THE LUNG?

23 A. IT'S CLASSIC. IT'S TYPICAL. THIS IS HOW PEOPLE  
24 PRESENT, BOTH IN TERMS OF HER CLINICAL SYSTEMS AND HER X-RAY  
25 APPEARANCE AND HER RESPONSE TO THERAPY. IT'S ACTUALLY A  
26 TYPICAL CASE. ABSOLUTELY.

27 Q. DID YOU JUST ACCEPT THE OPINIONS OF OTHER DOCTORS  
28 IN THE MEDICAL RECORDS AND REPORTS THAT YOU REVIEWED OR DID

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0028

1 YOU COME TO AN INDEPENDENT CONCLUSION YOURSELF?

2 A. THIS IS MY INDEPENDENT ASSESSMENT IN HAVING BEEN  
3 A PRACTICING PULMONARY PHYSICIAN FOR ALL THESE YEARS.

4 Q. NOW, HAVE YOU DONE BRONCHOSCOPIES ON PEOPLE WITH  
5 SMALL CELL LUNG CANCER?

6 A. YES.

7 Q. AND IS IT ALWAYS POSSIBLE ON A BRONCHOSCOPY TO  
8 FIND THE TUMOR?

9 A. NO.  
10 Q. HOW COMMON OR UNCOMMON IS THAT?  
11 A. HALF WAY.  
12 Q. HOW COMMON OR UNCOMMON IS IT TO HAVE NOT FOUND A  
13 LESION OR A PIECE OF THE TUMOR ON THE BRONCHOSCOPY?  
14 A. IT'S NOT UNUSUAL TO NOT BE ABLE TO SEE THE  
15 LESION.  
16 Q. AND WHY IS THAT?  
17 A. BECAUSE IT DEPENDS UPON WHERE THE LESION ARISES.  
18 IT'S QUITE COMMON TO SEE AN ENDOBRONCHIAL LESION, BUT YOU  
19 MAY NOT, BECAUSE IT DEPENDS UPON WHERE IT IS AND WHAT SORT  
20 OF LYMPH NODE INVOLVEMENT THERE IS AT THE TIME YOU'RE TRYING  
21 TO MAKE A DIAGNOSIS.  
22 BECAUSE YOU CAN'T GET -- WITH A BRONCHOSCOPE, YOU  
23 CAN'T GET INTO ALL OF THE LARGE AIRWAYS THAT YOU MIGHT WANT  
24 TO, PARTICULARLY IN THE UPPER LOBES. IT'S MORE DIFFICULT TO  
25 GET INTO THE LARGE AIRWAYS IN THE UPPER LOBES.  
26 Q. WHY IS THAT?  
27 A. BECAUSE OF THE ANATOMY, IT'S MORE DIFFICULT. AND  
28 THE INSTRUMENT JUST WON'T GO THERE AS EASILY AS IT CAN IN  
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0029

1 THE LOWER LOBES.  
2 IN ADDITION, THE SMALL CELL MALIGNANCIES NARROW  
3 THE AIRWAYS, AND THEY MAY NARROW THEM SUFFICIENTLY THAT YOU  
4 CAN'T GET THE BRONCHOSCOPE PAST AN AREA OF NARROWING OR THE  
5 INVOLVEMENT OF THE LYMPH NODES AROUND THE LARGE AIRWAYS  
6 EXTRINSICALLY COMPRESSES THE AIRWAYS.  
7 SO YOU CANNOT GET TO THE AREA WHERE THE  
8 ENDOBRONCHIAL LESION IS ACTUALLY AT.  
9 Q. NOW, WE'VE HEARD THIS TERMINOLOGY "ENDOBRONCHIAL  
10 LESION."  
11 CAN YOU EXPLAIN WHAT YOU MEAN BY IT AND --  
12 A. A TUMOR THAT IS SITTING IN THE PIPE THAT'S  
13 SITTING IN THE AIRWAY.  
14 Q. SO THIS WOULD BE INTO THE INTERIOR OF THE  
15 BRONCHIAL TUBE?  
16 A. RIGHT.  
17 Q. AND IS THERE ONLY ONE CELL LAYER ON THE BRONCHIAL  
18 TUBE; IN OTHER WORDS, IS IT MORE THAN ONE CELL THICK?  
19 A. OBVIOUSLY, IF IT WERE ONLY ONE CELL THICK, IT  
20 WOULD BE EXTRAORDINARILY FRAGILE.  
21 I MEAN, YOU'VE GOT TO GO THROUGH CELL BY CELL TO  
22 GET IN THERE. BUT YEAH, OF COURSE IT'S MORE THAN ONE CELL  
23 THICK.  
24 Q. DO ALL SMALL CELL CARCINOMAS OF THE LUNG START IN  
25 THE INTERIOR SECTION OF THE BRONCHUS, IN OTHER WORDS?  
26 A. ALL SMALL CELL CARCINOMAS ARE THOUGHT TO ARISE  
27 FROM THE LINING OF THE AIRWAY, BUT THAT DOESN'T MEAN YOU'D  
28 BE ABLE TO DIAGNOSE THEM BY BRONCHOSCOPE, BECAUSE THEY MAY  
JUDITH ANN OSSA, CSR NO. 2310

0030

1 NOT BE IN AN AREA THAT YOU CAN GET TO.  
2 Q. OKAY.  
3 A. OR IT MAY BE TOO FAR OUT TO GET TO.  
4 OCCASIONALLY, THEY OCCUR FARTHER THAN YOU CAN SEE.  
5 Q. WHAT DOES "SUBMUCOSAL" MEAN?  
6 A. UNDER THE LINING. THERE ARE CERTAIN CELLS THAT  
7 LINE THE AIRWAY. THE SUBMUCOSA ARE THE CELLS THAT ARE UNDER  
8 THAT.  
9 Q. CAN YOU MAYBE DRAW A LITTLE PICTURE SO THAT WE  
10 UNDERSTAND.  
11 A. (DRAWING PICTURE)

12           THERE ARE CELLS THAT LINE THE AIRWAYS, THESE  
13 LARGE AIRWAYS, LIKE SO. THERE'S AN AREA UNDER THESE CELLS  
14 THAT IS CALLED THE SUBMUCOSAL SPACE.  
15       Q.   NOW, WHERE IS THE AIR FLOW GOING?  
16       A.   HERE IS THE AIR (DRAWING).  
17       Q.   OKAY.  
18       A.   HERE'S THE SUBMUCOSA, AND DOWN HERE TOO.  
19       Q.   DO SMALL CELL CARCINOMAS OF THE LUNG SOMETIMES  
20 OCCUR IN THE SUBMUCOSAL AREA?  
21       A.   THEY CLEARLY SPREAD IN THE SUBMUCOSAL AREA. SO,  
22 FOR INSTANCE, IT IS NOT UNUSUAL FOR ME TO BRONCHOSCOPE  
23 SOMEBODY AND DIAGNOSE SMALL CELL CARCINOMA BY TAKING A  
24 BIOPSY, USING A BIOPSY INSTRUMENT THAT TAKES A CHUNK OF THE  
25 MUCOSA.  
26           AND THAT GOES INTO THE SUBMUCOSA. AND YOU  
27 DIAGNOSE THE MALIGNANCY IN THE SUBMUCOSA -- IN THE MUCOSA.  
28       Q.   SO YOU WOULDN'T BE ABLE TO SEE NECESSARILY A  
              JUDITH ANN OSSA, CSR NO. 2310

0031

1   LESION LOOKING THROUGH THE BRONCHOSCOPE, BUT YOU MIGHT  
2 TAKE --IS THAT A NEEDLE?  
3       A.   ACTUALLY, IT'S LIKE AN ALLIGATOR. IT'S AN  
4 INSTRUMENT THAT'S SHAPED LIKE THIS (DRAWING), AND IT CLOSES  
5 LIKE THIS, WITH THE EDGES BEING SHARP. AND SO YOU CUT THE  
6 TISSUE (INDICATING). IT CLOSES LIKE THAT (DEMONSTRATING).  
7       Q.   NOW, IS THERE SOMETHING CALLED CILIA?  
8       A.   YES.  
9       Q.   AND WHERE IS THAT IN RELATION TO WHAT WE'RE  
10 LOOKING AT?  
11       A.   CILIA ARE LITTLE HAIRLIKE -- MICROSCOPIC,  
12 HAIRLIKE STRUCTURES THAT ARE SITTING ON THE INSIDE OF THE  
13 AIRWAY. THEY'RE ON THE CELLS THAT LINE THE AIRWAY  
14 (DRAWING).  
15       Q.   WITHOUT ASKING YOU WHAT SORT OF THE ULTIMATE PLAN  
16 WAS FOR WHY THEY'RE THERE, WHAT DO CILIA DO?  
17       A.   IN THE LARGE AIRWAYS, THERE ARE MUCOUS GLANDS  
18 PRESENT THAT ARE SECRETING MUCUS, WHICH SIT ON TOP OF THE  
19 CILIA LIKE SO (DRAWING).  
20           IN THE URBAN ENVIRONMENT THAT WE LIVE IN, WE  
21 BREATHE IN -- I GUESS WE'LL CALL IT THE TECHNICAL TERM  
22 "CRUD," AND IF THE CRUD IS SMALL ENOUGH, IT MAKES ITS WAY  
23 DOWN INTO THE AREA WHERE THIS MECHANISM EXISTS.  
24           THE CILIA MOVE AND THEY MOVE RAPIDLY IN AN UPWARD  
25 DIRECTION, AND SLOWLY IN A DOWNWARD DIRECTION. AND THE NET  
26 EFFECT OF THAT IS TO MOVE THE MUCUS WHICH IS SECRETED IN THE  
27 AIRWAY, UP YOUR AIRWAY, CLEARING A LOT OF THE JUNK YOU  
28 BREATHE IN THIS ENVIRONMENT.

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0032

1       Q.   "JUNK" IS A LESS OR MORE SCIENTIFIC TERM THAN  
2 "CRUD"?  
3       A.   EQUAL.  
4       Q.   WHAT DOES CIGARETTE SMOKE DO TO CILIA? WHAT CAN  
5 IT DO?  
6       A.   IT PARALYZES THIS MUCOCILIARY MECHANISM, SO THAT  
7 YOU DON'T CLEAR THE CRUD.  
8       Q.   AND IF SOMEONE SMOKES AND SMOKES OVER TIME FOR A  
9 LONG PERIOD OF TIME, CAN THIS HAVE AN EFFECT OF STOPPING THE  
10 CILIA AND THE MUCUS FROM ACTUALLY REMOVING SUBSTANCES?  
11       A.   YES.  
12       MS. CHABER:   YOUR HONOR, SINCE WE'RE BREAKING  
13 EARLY TODAY, DO YOU WANT TO DO THE BREAK NOW?  
14       THE COURT:   I THINK THAT'S A GOOD IDEA.

15 JURORS, I'M GOING TO HAVE TO LET YOU GO SOMETIME  
16 AROUND 10 AFTER 4:00, 15 AFTER 4:00, BECAUSE I DO HAVE  
17 ANOTHER MATTER. THIS IS A GOOD TIME FOR OUR RECESS.

18 LET'S TAKE A 20-MINUTE RECESS UNTIL FIVE AFTER  
19 3:00. THEN WE'LL GO FOR ABOUT HOUR AND FIVE OR 10 MINUTES.  
20 PLEASE CONTINUE TO FOLLOW THE ADMONITION. WE'LL  
21 SEE YOU BACK AT FIVE AFTER 3:00.

22 (RECESS TAKEN FROM 2:45 TO 3:05 P.M.)

23 THE COURT: OKAY. WE'RE BACK ON THE RECORD.

24 JURORS, JUST ONE SCHEDULING MATTER. AFTER  
25 TALKING TO THE LAWYERS, THEY ARE GOING TO TRY, BUT ARE NOT  
26 SURE THAT THEY CAN FINISH, BOTH OF THEM, WITH DR. HORN THIS  
27 AFTERNOON.

28 I HAVE TOLD THEM THAT EVEN THOUGH IT'S  
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0033

1 INCONVENIENT FOR MY SCHEDULE, I WOULD STAY WITH YOU IN THIS  
2 CASE UNTIL 4:30, IF THEY CAN GET IT DONE.

3 BUT LET ME JUST SAY TO COUNSEL, IF AT ANY TIME IN  
4 THE NEXT FEW MINUTES OR WHENEVER, YOU REALIZE THAT YOU  
5 CANNOT GET IT DONE BY 4:30, LET ME KNOW, BECAUSE I NEED TO  
6 THEN GO TO MY OTHER CASE.

7 I'M JUST GOING TO STAY WITH YOU AGAINST THE  
8 POSSIBILITY THAT YOU CAN GET ALL OF THIS DONE. ALL RIGHT.  
9 MS. CHABER.

10 MS. CHABER: Q. I WOULD SAY I WOULD TALK  
11 FASTER AND DR. HORN WOULD TALK FASTER, BUT I DON'T KNOW IF  
12 WE WOULD BE APPRECIATED ON THAT.

13 THE COURT: WELL, JUDITH WILL DO HER BEST TO  
14 HELP US OUT, I'M SURE.

15 JUROR NO. 2: GO JUDITH.

16 MS. CHABER: Q. OKAY. DR. HORN, DOES THE FACT  
17 THAT MS. HENLEY HAS EMPHYSEMA IN ANY WAY DOCUMENT FOR YOU  
18 THE VALIDITY OF THE SMOKING HISTORY SHE GAVE YOU?

19 A. YES.

20 Q. AND HOW IS THAT?

21 A. PEOPLE WHO HAVE LUNG FUNCTION TEST ABNORMALITIES  
22 LIKE HERS ARE ALMOST ALWAYS CIGARETTE SMOKERS.

23 Q. CAN YOU TELL US VERY BRIEFLY WHAT LUNG FUNCTION  
24 TESTS ARE AND HOW THEY SUPPORT WHAT YOU JUST SAID.

25 A. THESE ARE TESTS DONE WHERE WE MEASURE THE AMOUNT  
26 OF AIR IN THE LUNG. AS YOU'RE SITTING HERE, YOU HAVE A  
27 CERTAIN AMOUNT OF AIR IN YOUR LUNG. IF YOU TAKE A DEEP  
28 BREATH AND HOLD YOUR BREATH, HOLD IT IN ALL THE WAY, THERE

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0034

1 IS MORE AIR IN YOUR LUNG.

2 IN A LABORATORY, WE CAN MEASURE THE AMOUNT OF AIR  
3 THAT'S ACTUALLY PRESENT IN YOUR LUNG. IN ADDITION, WE CAN  
4 LEARN SOMETHING FUNCTIONAL ABOUT YOUR LUNG; THAT IS, HOW  
5 FAST YOU CAN BRING AIR IN AND BLOW AIR OUT OF YOUR LUNG.

6 IF YOUR AIRWAYS ARE NARROWED, YOU CAN'T BLOW AIR  
7 OUT OF YOUR LUNG AS RAPIDLY AS YOU WOULD BE ABLE TO IF YOUR  
8 AIRWAYS ARE NORMAL. IT'S LIKE A SINK AT HOME. IF YOU HAVE  
9 A SINK THAT'S PLUGGED UP, WATER DOESN'T FLOW THROUGH THE  
10 PIPES AS NICELY AS IT WOULD IF YOU GET RID OF THE  
11 OBSTRUCTION.

12 AIR BEHAVES THE SAME AS FLUID, AND IF THE AIRWAYS  
13 ARE NARROWED, THERE'S IMPAIRMENT IN THE FLOW OF AIR. SO WE  
14 CAN MEASURE THAT. WE CAN MEASURE SOMETHING CALLED THE  
15 DIFFUSING CAPACITY.

16 THIS IS DONE BY HAVING INDIVIDUALS INHALE A  
17 DILUTE AMOUNT OF CARBON MONOXIDE. CARBON MONOXIDE BINDS THE

18 HEMOGLOBIN IN THE LUNG, AND THE UPTAKE OF CARBON MONOXIDE IN  
19 THE LUNG SAYS SOMETHING ABOUT THE EFFICIENCY OF HOW YOUR  
20 LUNG WORKS; THAT IS, AIR AND BLOOD MATCH, SO THAT YOU PICK  
21 UP THE CARBON MONOXIDE.

22 IF IT'S REDUCED, IT MEANS THAT THERE'S SOMETHING  
23 WRONG WITH THE LUNG.

24 Q. AND THOSE TESTS WERE DONE ON MS. HENLEY?

25 A. YES.

26 Q. AND WHAT DID THEY DEMONSTRATE?

27 A. THE TESTS ARE CLEARLY ABNORMAL. THE MAJOR  
28 ABNORMALITY, SHE HAS AIRWAYS OBSTRUCTION. THERE IS A  
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0035

1 NARROWING OF HER AIRWAYS, WHICH IS A COMPLICATION OF  
2 CIGARETTE SMOKING.

3 IN ADDITION, THE DIFFUSING CAPACITY, THE UPTAKE  
4 OF CARBON MONOXIDE, IS VERY LOW, MEANING THAT THERE HAS BEEN  
5 SOME VERY CONSIDERABLE DESTRUCTION IN HER LUNGS. SHE HAS A  
6 CONSIDERABLE DEGREE OF EMPHYSEMA FROM HER CIGARETTE SMOKING.

7 Q. NOW, WITH RESPECT TO THE LUNG CANCER, CAN YOU  
8 SHOW US BY WAY OF THE X-RAYS OR THE CT SCANS WHERE THE  
9 DISEASE BEGAN AND HOW IT HAS PROGRESSED.

10 THE COURT: IS THIS ANOTHER AREA WHERE WE HAVE  
11 AN AGREEMENT BETWEEN COUNSEL THAT CERTAIN MATERIAL CAN BE  
12 SHOWN TO THE JURY WITHOUT BEING MARKED FOR IDENTIFICATION?

13 MR. OHLEMEYER: YES, YOUR HONOR.

14 THE COURT: OKAY.

15 THE COURT: YOU MAY PROCEED.

16 NOT TOO FAR BACK. THE JURORS NEED TO BE ABLE TO  
17 SEE IT.

18 THE JURORS NEED TO LET US KNOW IF THEY CAN'T SEE  
19 IT.

20 THE WITNESS: I'M GOING TO SHOW YOU SOME COPIES  
21 OF CHEST X-RAYS. THESE ARE NOT ALL THE FILMS THAT  
22 MS. HENLEY HAS, BUT THESE ARE A SELECTION OF FILMS SO YOU  
23 GET SOME IDEA OF WHAT HAPPENED HERE.

24 THE FIRST FILM IS DATED JANUARY 3RD, 1998. THE  
25 FILM THAT I'M REFERRING TO NOW IS, IF YOU'RE TAKING AN  
26 X-RAY, YOU'RE LOOKING AT ME, THIS IS MY RIGHT SIDE, THIS IS  
27 MY LEFT SIDE (INDICATING).

28 THIS REPRESENTS MS. HENLEY'S RIGHT LUNG RIGHT  
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0036

1 HERE. WHERE YOU SEE BLACK MEANS AIR. WHERE YOU SEE WHITE  
2 MEANS THAT THERE IS FLUID DENSITY.

3 SO THIS STRUCTURE THAT'S SITTING RIGHT HERE IS  
4 MR. HENLEY'S HEART, RIGHT HERE. THERE'S BLOOD IN THE HEART  
5 SO IT HAS A FLUID STRUCTURE.

6 IN THE RIGHT PORTION OF THE DIAPHRAGM OVER HERE,  
7 BELOW THE DIAPHRAGM, IS THE LIVER. THE LIVER IS FULL OF  
8 BLOOD. HENCE, IT'S WHITE.

9 THIS IS THE LEFT LUNG SITTING OVER HERE. THIS IS  
10 THE LEFT PORTION OF THE DIAPHRAGM. WHAT'S ABNORMAL ON THIS  
11 X-RAY IS SITTING RIGHT HERE. THIS IS ABNORMAL.

12 THERE IS A DENSITY SITTING IN THE LEFT SIDE OF  
13 THE CHEST. IT'S CENTRAL. IT'S IN THE AREA OF WHAT'S CALLED  
14 THE LEFT HILUM. THE HILUM IS WHERE THE BLOOD VESSELS AND  
15 THE AIRWAYS ENTER THE LEFT LUNG.

16 THIS REPRESENTS THE RIGHT HILAR OVER HERE. THIS  
17 IS THE LEFT HILAR AREA. THIS IS ALL ABNORMAL.

18 MS. CHABER: Q. IS THE HILUM THE ROOT OF THE  
19 LUNG?

20 A. YES.

21 THE OTHER X-RAY IS A LATERAL FILM HERE. THE WAY  
22 THE FILM IS TAKEN THIS WAY, WITH THE PLATE SITTING BACK  
23 HERE, THIS IS WHAT SHE LOOKS LIKE FROM THE SIDE.  
24 AND WE CAN SEE ACTUALLY A FAIRLY LARGE MASS  
25 SITTING RIGHT HERE, ACTUALLY PRETTY LARGE. IT'S MORE  
26 OBVIOUS ON THE LATERAL FILM THAN IT IS ON THIS FILM.  
27 Q. AND IN TERMS OF WHAT YOU'RE SEEING, CAN YOU  
28 DETERMINE WHERE THE LOCATION OF THAT MASS IS ON THAT LATERAL  
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0037

1 FILM OR ON EITHER OF THEM?  
2 A. NO. ALL YOU CAN SAY IS IT'S CENTRAL IN THE  
3 CHEST, HEADING TOWARDS THE UPPER LUNG, AND FEEDS IT FAIRLY  
4 EXTENSIVELY.  
5 SO IT'S SITTING IN HERE, LIKE SO.  
6 Q. ALL RIGHT.  
7 A. THAT X-RAY LED TO A CT SCAN OF THE CHEST BEING  
8 DONE. A CT SCANNER IS A LARGE MACHINE IN THE SHAPE OF A  
9 DOUGHNUT, A VERTICAL DOUGHNUT ABOUT EIGHT FEET IN DIAMETER.  
10 AND PATIENTS GO IN THE MIDDLE, IN THAT DOUGHNUT  
11 AND X-RAY BEAM. IT TYPICALLY SENDS OUT AN X-RAY BEAM THAT'S  
12 ONE CENTIMETER WIDE THAT GOES ALL THE WAY AROUND.  
13 IT TAKES AN X-RAY CONTINUOUSLY AROUND YOU. IT  
14 SHOWS YOU WHAT YOU LOOK LIKE IN CROSS-SECTION.  
15 HERE IS THE TINY PICTURE OF AN X-RAY WITH LINES  
16 ACROSS IT. THESE LINES ALL REPRESENT IMAGES. IT'S AS IF  
17 THE X-RAY MACHINE TOOK MS. HENLEY AND CUT HER LIKE A  
18 GUILLOTINE EVERY CENTIMETER OR 3/8 OF AN INCH.  
19 EACH OF THESE IS NUMBERED. YOU CAN USE THIS TO  
20 LOOK AT SOME CROSS-SECTIONS.  
21 I'LL SHOW YOU. HERE ARE SOME OF THE IMAGES THAT  
22 WERE DONE, AND YOU ARE GOING TO HAVE TO TRUST ME ON THIS.  
23 EACH OF THESE IMAGES IS NUMBERED. THIS IS ONE OF THE  
24 NUMBERS OVER HERE.  
25 THE IMAGES THAT ARE ABNORMAL ARE IN THIS REGION  
26 RIGHT HERE, AND THEY'RE CLEARLY ABNORMAL.  
27 SO IF WE LOOK HERE AT IMAGE NO. 8, IF YOU SEE  
28 THIS WHITE AREA RIGHT HERE, WHICH I'M OUTLINING WITH MY PEN.  
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0038

1 Q. THAT'S THE CENTER?  
2 A. THAT IS IN THE CENTER. THIS IS THE AORTA.  
3 WHAT HAPPENED WHEN THEY DID THIS CHEST X-RAY,  
4 THEY GAVE A RADIOPAQUE DYE WHICH WOUND UP IN THE  
5 CIRCULATION.  
6 THIS IS THE BLOOD, SHOWING UP VERY BRIGHT.  
7 HERE, THAT'S THE AORTA, AND ADJACENT TO THE AORTA  
8 IS A MASS IN THE LUNG. HERE IS ANOTHER PICTURE OF THE  
9 AORTA. THIS IS ONE CENTIMETER DOWN. THIS IS THE MASS IN  
10 THE LUNG.  
11 IF WE GO DOWN ANOTHER CENTIMETER, HERE IS THE  
12 AORTA. THIS ONE IS THE -- THIS IS THE ASCENDING AORTA, HERE  
13 IS THE DESCENDING AORTA. AND HERE IS A LARGE MASS IN  
14 BETWEEN. IF WE KEEP GOING, WE SEE A LARGE MASS. HERE IS  
15 THE AIRWAY.  
16 THIS IS THE LEFT MAIN STEM BRONCHUS RIGHT HERE.  
17 THE TRACHEA COMES DOWN AND DIVIDES INTO THE AIRWAY WHICH  
18 GOES TO THE RIGHT LUNG, WHICH IS THE RIGHT MAIN STEM  
19 BRONCHUS AND AN AIRWAY WHICH GOES TO THE LEFT LUNG, WHICH IS  
20 THE LEFT MAIN STEM BRONCHUS.  
21 THIS MAIN STEM BRONCHUS IS BEING NARROWED BY THE  
22 TUMOR HERE. SO IF I SAW THIS, I WOULD SAY, "WELL, THE  
23 BRONCHOSCOPIST IS GOING TO HAVE TROUBLE MAKING A DIAGNOSIS

24 BY BRONCHOSCOPY. IT MIGHT BE DIFFICULT. THEY MIGHT OR  
25 MIGHT NOT BE ABLE TO MAKE A DIAGNOSIS."  
26 Q. WHAT SIGNIFICANCE WOULD THAT HAVE?  
27 A. BECAUSE YOU CAN'T GET THE SCOPE PAST THAT POINT.  
28 YOU CAN'T GET THE BRONCHOSCOPE PAST THERE. YOU ARE STUCK  
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0039

1 THERE. SO YOU MIGHT SEE A LESION RIGHT HERE, BUT YOU MIGHT  
2 NOT SEE A LESION RIGHT HERE, BECAUSE THIS IS -- THIS STARTS  
3 IN THE AIRWAY, BUT IT CAN -- IT MAY START FARTHER UP AND  
4 THEN PROCEED TO SPREAD.

5 AND THE AIRWAY IS NARROWED RIGHT THERE, SO YOU  
6 MIGHT OR MIGHT OR NOT BE ABLE TO MAKE A DIAGNOSIS.

7 THE NEXT X-RAY IS DATED JANUARY 30TH, 1998. SO  
8 IT'S FOUR WEEKS APART. AND THE MASS LESION IS MORE OBVIOUS  
9 HERE. HERE, THIS IS ABNORMAL. THIS IS ALL MASS SITTING  
10 RIGHT HERE. HERE IS THE ARCH OF THE AORTA RIGHT HERE. THE  
11 LUNG SHOULD COME RIGHT TO THE ARCH OF THE AORTA, BUT IT  
12 DOESN'T BECAUSE THERE'S A MASS SITTING IN HERE.

13 AND THIS IS ONLY IN A FOUR-WEEK PERIOD, SO THAT  
14 THIS LESION IS GROWING VERY RAPIDLY. THIS IS VERY RAPID.

15 HERE IS AN X-RAY DATED MARCH 4TH, SO IT'S A  
16 LITTLE MORE THAN A MONTH LATER, AND IT'S EVEN BIGGER HERE.  
17 THIS IS QUITE A LARGE LESION SITTING RIGHT HERE. AND IT'S  
18 MUCH MORE OBVIOUS THAN YOU COULD SEE BACK HERE.

19 HERE, THIS IS JANUARY 3RD. THIS IS MARCH 4TH,  
20 TWO MONTHS LATER. THE LESION IS MUCH LARGER THAN IT WAS  
21 EARLIER, AND IT'S GROWING QUITE RAPIDLY.

22 Q. SHE HAD HAD NO TREATMENT FROM THE TIME OF THE  
23 JANUARY 3RD TO THE MARCH 4TH X-RAY?

24 A. NO, BECAUSE THIS WAS RIGHT AFTER THAT POINT THAT  
25 SHE BEGAN RECEIVING -- ACTUALLY, SHE GOT HER FIRST  
26 CHEMOTHERAPY THAT DAY.

27 Q. OKAY.

28 A. ON MARCH 4TH. AND SO, IN THAT TWO-MONTH TIME  
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0040

1 PERIOD, THIS CANCER IS GROWING PRETTY QUICKLY, VERY  
2 RAPIDLY. THAT'S CALLED THE DOUBLING TIME OF TUMOR. THAT IS  
3 HOW LONG IT TAKES FOR THE TUMOR TO DOUBLE IN SIZE, FOR THE  
4 TOTAL NUMBER OF CELLS PRESENT TO DOUBLE.

5 TYPICALLY FOR THIS KIND OF MALIGNANCY, THE  
6 DOUBLING TIME IS VERY RAPID COMPARED TO MOST OTHER  
7 MALIGNANCIES. THIS IS VERY TYPICAL FOR SMALL CELL CARCINOMA  
8 OF THE LUNG.

9 HERE IS THE X-RAY ON APRIL 24TH. SHE HAS NOW  
10 RECEIVED MULTIPLE COURSES OF TREATMENT, AND YOU CANNOT SEE  
11 AN ABNORMALITY ON THIS X-RAY HERE. THAT IS, THAT THIS TUMOR  
12 JUST SORT OF MAGICALLY DISAPPEARED WITH TREATMENT.

13 HERE IS THIS MASS SITTING RIGHT HERE, AND IT  
14 ISN'T THERE ANYMORE. HERE IS THE ARCH OF THE AORTA. THIS  
15 IS -- THIS IS A NORMAL X-RAY.

16 Q. DOES THAT MEAN SHE IS CURED?

17 A. SHE IS NOT CURED, BUT THIS IS VERY TYPICAL OF  
18 SMALL CELL CARCINOMA OF THE LUNG. IT INITIALLY RESPONDS  
19 VERY WELL TO CHEMOTHERAPY, BUT YOU DO NOT GET RID OF ALL OF  
20 THE CELLS. YOU GET RID OF THE GREAT MAJORITY OF CELLS, AND  
21 IT'S VERY COMMON FOR THE TUMOR TO APPEAR TO JUST MELT AWAY  
22 AND THERE AIN'T NO MORE TUMOR.

23 BUT WE KNOW, IN FOLLOWING LARGE NUMBERS OF PEOPLE  
24 WITH THIS MALIGNANCY OVER TIME, THAT IN FACT THE  
25 CHEMOTHERAPY DOES NOT CURE THE MALIGNANCY, THAT IT IN FACT  
26 COMES BACK.

27 Q. THIS IS DRIVING ME CRAZY BECAUSE YOU KEEP  
28 STEPPING ON IT (REFERRING TO WIRING).

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0041

1 A. YES. YOU CAN ALSO SEE ON THE LATERAL FILM THAT  
2 THERE'S A VERY DRAMATIC DIFFERENCE AS WELL.

3 HERE, THIS IS THE LATERAL FILM FROM MARCH 4TH,  
4 AND HERE IS ONE FROM APRIL 24TH. THERE IS A LARGE LESION  
5 SITTING HERE, AND I DON'T SEE IT AT ALL OVER HERE AS WELL.  
6 I JUST DON'T SEE IT. YOU HAVE TO TRUST ME. I KNOW YOU'RE  
7 NOT RADIOLOGISTS. I JUST DON'T SEE IT ANYMORE AT ALL. SO  
8 SHE MAGICALLY RESPONDED VERY NICELY TO THE CHEMOTHERAPY.

9 THE LAST CHEST X-RAY I HAVE AVAILABLE, ACTUALLY,  
10 IS THE ONE THAT WAS OBTAINED AT ALTA BATES. AND THIS IS ON  
11 AUGUST 11TH. AND YOU CAN SEE THAT THIS FILM APPEARS  
12 DIFFERENT THAN THIS APRIL 24TH FILM.

13 HERE IS THE APRIL 24TH FILM, WHERE I DON'T -- I  
14 DON'T SEE ANYTHING IN THERE. BUT NOW, THERE IS SCARRING IN  
15 HERE, EXTENDING UP TO THE UPPER LUNG FIELD. ALL THESE  
16 LINEAR SHADOWS HERE ARE REPRESENTING SCARS AND POTENTIALLY A  
17 MASS IN THERE AS WELL. I CAN'T TELL. BUT THIS IS CLEARLY  
18 DIFFERENT THAN WHAT IT LOOKS LIKE IN APRIL.

19 SO THAT THERE ARE CHANGES. IN THE INTERIM, SHE  
20 RECEIVED MORE CHEMOTHERAPY AND ALSO RECEIVED RADIATION  
21 THERAPY TO THE CHEST.

22 Q. ARE SOME OF THE EFFECTS THAT YOU'RE SEEING THERE  
23 DUE TO THE RADIATION?

24 A. SOME OF THESE EFFECTS ARE CLEARLY DUE TO  
25 RADIATION.

26 THE LAST X-RAY TECHNIQUE I HAVE AVAILABLE IS A CT  
27 SCAN OF THE CHEST OBTAINED ON OCTOBER 10TH, 1998.

28 AGAIN, HERE IS THE AORTA SITTING HERE, AND THERE  
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0042

1 IS SOMETHING GOING ON UP OVER HERE, LINEAR SCARRING. AND  
2 THERE'S ALSO A DENSITY SITTING RIGHT HERE. THIS IS ON IMAGE  
3 NO. 10. ON IMAGE NO. 9, THERE IS LINEAR SCARRING IN HERE AS  
4 WELL, A DENSITY THAT HAS THE APPEARANCE OF A MASS.

5 AND THIS COULD WELL REPRESENT RECURRENCE OF THE  
6 TUMOR, AND THE TIME COURSE WOULD BE CONSISTENT WITH  
7 RECURRENCE OF THE TUMOR AS WELL.

8 Q. NOW, THE LINEAR SPREADING THAT'S THERE, IS SOME  
9 OF THAT DUE TO THE RADIATION?

10 A. I'M SURE AT LEAST SOME OF IT IS DUE TO RADIATION.

11 Q. WHEN YOU SAY "A DENSITY," WHAT DO YOU MEAN BY "A  
12 DENSITY"?

13 A. A MASS.

14 Q. THAT'S ACTUALLY IN THE LUNG?

15 A. IN THE LUNG.

16 Q. DID YOU SEE ANY MASSES IN THE LUNG IN THE JANUARY  
17 CT OR --

18 A. THE STUFF THAT'S OUTSIDE THE AORTA, LATERAL TO  
19 THE AORTA, THAT'S IN THE LUNG. THAT'S TUMOR IN THE LUNG.

20 Q. AND HOW DO YOU KNOW THAT?

21 A. THERE IS THE LUNG RIGHT THERE. IF YOU LOOKED AT  
22 A NORMAL CT SCAN, THIS LUNG GOES RIGHT OVER, RIGHT UP TO THE  
23 ARCH OF THE AORTA. THAT'S TUMOR IN THE LUNG. THAT'S IT.

24 Q. IN EVALUATING MS. HENLEY AND DETERMINING THAT SHE  
25 HAD A LUNG CANCER, DID YOU TAKE INTO CONSIDERATION ANY OTHER  
26 SITES OR LOCATIONS THAT THIS CANCER MIGHT BE?

27 A. THERE'S NO EVIDENCE IN THE CLINICAL RECORDS OR  
28 X-RAYS THAT SHE HAS A PRIMARY MALIGNANCY THAT AROSE

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0043

1 ELSEWHERE AND SPREAD TO THE LUNG.

2 Q. NOW, THERE WAS A BIG MASS THAT WE COULD SEE ON  
3 THAT CHEST X-RAY?

4 A. YES.

5 Q. WAS ALL OF THAT IN THE LUNG?

6 A. NO. SOME OF IT IS IN THE MIDDLE OF THE -- THERE  
7 ARE HILAR LYMPH NODES AND MEDIASTINAL LYMPH NODES INVOLVED.

8 CHARACTERISTICALLY, SMALL CELL MALIGNANCIES OF  
9 THE LUNG SPREAD FROM THE LUNG TO THE LYMPH NODES VERY  
10 RAPIDLY. SO THIS IS A VERY CLASSIC PRESENTATION FOR  
11 SOMEBODY WITH A SMALL CELL MALIGNANCY OF THE LUNG.

12 Q. AND THE FACT THAT THERE IS THIS ENLARGEMENT OF  
13 THE MEDIASTINUM, IS THAT ALSO CONSISTENT WITH IT BEING A  
14 SMALL CELL CANCER OF THE LUNG?

15 A. YES. THAT'S HOW THEY TYPICALLY PRESENT.

16 Q. THIS IS SOMETHING THAT YOU'VE SEEN BEFORE?

17 A. OH, SOME ENORMOUS NUMBER OF TIMES.

18 Q. NOW, IN LOOKING AT MS. HENLEY'S CASE, DID YOU  
19 HAVE AN OPPORTUNITY TO LOOK AT THE MEDICAL PROCEDURES THAT  
20 WERE DONE AND THE BILLING THAT WAS DONE AS WELL?

21 A. YES.

22 Q. CAN YOU TELL US, TO DATE, THE APPROXIMATE AMOUNT  
23 OF MEDICAL COST FOR MS. HENLEY'S DIAGNOSIS, CARE AND  
24 TREATMENT?

25 A. UP UNTIL MID-DECEMBER, ROUGHLY \$75,000.

26 Q. NOW, AS PART OF THE DIAGNOSIS, WHAT YOU DO AS A  
27 PULMONARY DOCTOR AND A CRITICAL CARE MEDICINE SPECIALIST, DO  
28 YOU LOOK AT WHAT ARE THE CONSEQUENCES OF A DISEASE DOWN THE  
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0044

1 ROAD TO PEOPLE?

2 A. YES.

3 Q. AND CAN YOU TELL US WHAT THE LIKELY COURSE IS  
4 THAT MS. HENLEY'S DISEASE WILL TAKE?

5 A. THE DISEASE WILL RECUR LOCALLY AND THEN SPREAD TO  
6 DISTANT SITES. IT CAN SPREAD -- COMMONLY, THIS MALIGNANCY  
7 SPREADS TO THE BRAIN. IT SPREADS TO BONE. IT SPREADS TO  
8 OTHER ORGANS.

9 LATE IN THE COURSE OF THE DISEASE, IT'S NOT  
10 UNUSUAL FOR THE PEOPLE TO HAVE A LOT OF PAIN, TO BE SHORT OF  
11 BREATH, TO BE WEAK, TO LOSE WEIGHT, AND PROGRESSIVELY  
12 REQUIRE MORE AND MORE CARE UNTIL THEY REQUIRE CARE 24 HOURS  
13 A DAY, SEVEN DAYS A WEEK.

14 Q. AND IS IT LIKELY THAT MS. HENLEY WILL HAVE OTHER  
15 HOSPITALIZATIONS?

16 A. IT IS MORE LIKELY THAN NOT SHE WILL HAVE AT LEAST  
17 ONE MORE HOSPITALIZATION.

18 Q. AND CAN YOU GIVE US AN ESTIMATE OF WHAT THE  
19 FUTURE MEDICAL CARE AND TREATMENT MS. HENLEY IS LIKELY TO OR  
20 WILL COST?

21 A. ASSUMING SHE DOES NOT HAVE ANY HEROIC CARE?

22 Q. MEANING WHAT? LIFE SUPPORT, THINGS LIKE THAT?

23 A. LIFE SUPPORT. IF SHE GETS VERY SICK AND SHE'S  
24 STUCK IN THE ICU FOR WEEKS AT A TIME, IF SHE IS PROVIDED  
25 SUPPORTIVE CARE, ABOUT \$50,000.

26 Q. AND THAT WOULD BE ADDITIONAL TO WHAT IT HAS  
27 ALREADY COST?

28 A. YES.

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0045

1 Q. AND MS. HENLEY HAS SURVIVED NOW FROM THE  
2 DIAGNOSIS IN EARLY FEBRUARY TO NOW, THE END OF JANUARY OF

3 THE FOLLOWING YEAR.

4 IS THAT UNUSUAL WITH SOMEONE WITH SMALL CELL  
5 CARCINOMA OF THE LUNG?

6 A. NO. IN INDIVIDUALS WHICH PRESENT WITH WHAT LOOKS  
7 LIKE SMALL CELL CARCINOMA LIMITED TO THE CHEST, EVEN THOUGH  
8 WE KNOW IT'S NOT JUST LIMITED TO THE CHEST, THE AVERAGE  
9 SURVIVAL IS SOMETHING IN THE ORDER OF ABOUT 20 MONTHS.

10 Q. AND IS THERE ANYTHING INCONSISTENT ABOUT HER  
11 HAVING SURVIVED 12 MONTHS, A LITTLE BIT LONGER, WITH THIS  
12 BEING A SMALL CELL CARCINOMA OF THE LUNG, AS OPPOSED TO SOME  
13 OTHER CYTOLOGY?

14 A. NOT AT ALL.

15 Q. WHAT IS THE LIKELY COURSE FOR MS. HENLEY?

16 A. SHE WILL ULTIMATELY DIE OF COMPLICATIONS OF THIS  
17 MALIGNANCY, PRIMARILY BECAUSE OF SPREAD TO DISTANT SITES.

18 MS. CHABER: I HAVE NOTHING FURTHER.

19 THE COURT: OKAY. MR. OHLEMEYER.

20 MR. OHLEMEYER: BRIEFLY, YOUR HONOR.

21  
22 CROSS-EXAMINATION

23 BY MR. OHLEMEYER: Q. GOOD AFTERNOON, DOCTOR.

24 A. GOOD AFTERNOON.

25 Q. I THINK I WILL BE BRIEF, BUT I WANT TO ASK YOU A  
26 COUPLE OF QUESTIONS, FIRST OF ALL, ABOUT THESE X-RAYS.

27 YOU SUGGESTED TO THE JURY THAT THEY WERE NOT  
28 RADIOLOGISTS.

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0046

1 DO YOU REMEMBER THAT COMMENT?

2 A. WELL, I DON'T KNOW WHAT THEY DO, BUT IT WOULD BE  
3 UNLIKELY THEY ARE RADIOLOGISTS. THERE COULD BE RADIOLOGISTS  
4 HERE, BUT NOT LIKELY.

5 Q. AND YOU ARE NOT A RADIOLOGIST, ARE YOU?

6 A. NO, ALTHOUGH I READ MORE CHEST X-RAYS. EVERY DAY  
7 I GO TO WORK, I READ CHEST X-RAYS AND LOOK AT CT SCANS OF  
8 THE CHEST. AND I PROBABLY SEE MORE X-RAYS OF THE CHEST THAN  
9 THE GREAT MAJORITY OF RADIOLOGISTS, WITH THE EXCEPTION OF  
10 CHEST RADIOLOGISTS, BECAUSE I DO THAT EVERY DAY. THEY DON'T  
11 DO THAT EVERY DAY.

12 THEY LOOK AT LOTS OF OTHER KINDS OF X-RAYS WHICH  
13 I DON'T LOOK AT.

14 Q. THERE ARE DOCTORS AT HOSPITALS, INCLUDING YOURS,  
15 WHOSE SPECIALTY IS CREATING AN X-RAY OR A CT SCAN AND THEN  
16 DESCRIBING IN A REPORT WHAT THEIR IMPRESSION IS, BASED ON  
17 THEIR BACKGROUND, THEIR EDUCATION, THEIR EXPERIENCE?

18 A. THERE ARE RADIOLOGISTS AT ALTA BATES WHO  
19 INTERPRET FILMS EVERY DAY.

20 Q. AND WITH RESPECT TO MS. HENLEY, FOR EVERY ONE OF  
21 THESE X-RAYS OR CT SCANS YOU SHOWED US, THERE WAS A  
22 RADIOLOGIST IN LOS ANGELES WHO EITHER PRESCRIBED OR ORDERED  
23 THE FILMS TO BE DONE AND THEN PREPARED A REPORT THAT  
24 DESCRIBED WHAT HE OR SHE SAW IN THAT FILM; RIGHT?

25 A. WELL, ACTUALLY, ANOTHER PHYSICIAN ORDERED THE  
26 FILM. THE RADIOLOGIST INTERPRETED THE FILM.

27 Q. AND YOU'VE SEEN THOSE, OR THAT REPORT, HAVEN'T  
28 YOU?

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0047

1 A. AT SOME TIME OR ANOTHER, I'VE SEEN ALL THOSE  
2 REPORTS.

3 Q. LET ME HAND IT TO YOU. IT'S DEFENDANT'S EXHIBIT  
4 2790.

5 YOU HAVE SEEN THAT BEFORE; RIGHT?

6 A. YES.  
7 Q. AND IN THAT REPORT, THE DOCTORS DON'T SAY THERE  
8 IS TUMOR IN THE LUNG, DO THEY?  
9 A. THEY SAY:  
10 "INCREASED SOFT TISSUE DENSITY IS EVIDENT IN A  
11 PORTION OF THE RETROSTERNAL SPACE AND THE LEFT  
12 HILUM AND LEFT UPPER MEDIASTINUM APPEAR  
13 ABNORMALLY PROMINENT."  
14 Q. AND THERE IS A REFERENCE IN THE CT REPORT TO THE  
15 LUNG FIELD'S BEING CLEAR; ISN'T THAT RIGHT?  
16 A. "A MASS IS EVIDENT EXTENDING ALONG THE LEFT  
17 MARGIN OF THE AORTIC ARCH DOWN TO AND ENCIRCLING  
18 THE LEFT HILUM AND LEFT MAINSTEM BRONCHUS. AT  
19 THE LEVEL OF THE HILUM AND MAINSTEM BRONCHUS IT  
20 HAS A MAXIMUM DIAMETER OF APPROXIMATELY SIX  
21 CENTIMETERS."  
22 Q. ISN'T THERE A REFERENCE TO THE LUNG -- MAY I SEE  
23 IT? I WILL DIRECT YOUR ATTENTION TO IT.  
24 OH, RIGHT AT THE BEGINNING. "THE LUNGS APPEAR  
25 CLEAR."  
26 A. "THE LUNGS APPEAR CLEAR EXCEPT FOR A FAINT  
27 INFILTRATE IN THE SUPERIOR SEGMENT OF THE LEFT  
28 LOWER LOBE."

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0048

1 Q. AND THERE IS NOTHING IN THESE REPORTS ABOUT LYMPH  
2 NODE INVOLVEMENT; RIGHT?  
3 A. THE RADIOLOGIST DOESN'T COMMENT ON LYMPH NODE  
4 INVOLVEMENT.  
5 Q. YOU HAVE SEEN THE SURGICAL PATHOLOGY REPORT IN  
6 THIS CASE?  
7 A. YES.  
8 Q. THAT'S DEFENDANT'S EXHIBIT 2792. I HAND IT TO  
9 YOU.  
10 THAT'S THE PATHOLOGIST'S INTERPRETATION OF THE  
11 BIOPSY SPECIMEN?  
12 A. RIGHT.  
13 Q. NOTHING IN THERE ABOUT LYMPH NODES BEING BIOPSIED  
14 OR INVOLVED IN THAT SPECIMEN?  
15 A. THE PATHOLOGIST INDICATES THAT THEY WERE -- WHAT  
16 WAS BIOPSIED WAS THE LEFT HILAR MASS, AND THE DIAGNOSIS OF  
17 SMALL CELL CARCINOMA WAS MADE.  
18 Q. NOTHING ABOUT LYMPH NODES OR LYMPH NODE  
19 INVOLVEMENT OR LYMPHOCYTES BEING EXAMINED; RIGHT?  
20 A. NOTHING ABOUT THAT.  
21 Q. AND THEN THE CT SCAN FROM OCTOBER OF 1998 THAT  
22 YOU TALKED ABOUT?  
23 A. YES.  
24 Q. THE DOCTOR WHO SIGNED THAT REPORT SPECIFICALLY  
25 SAID "NO DEFINITE MASS IS IDENTIFIED; ISN'T THAT RIGHT?  
26 A. RIGHT.  
27 Q. HE DIDN'T SAY THERE WAS A TUMOR IN THE LUNG ON  
28 THE CT SCAN, DID HE?

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0049

1 A. HE DID NOT. BUT HE CLEARLY INDICATED THAT IT WAS  
2 ABNORMAL, YES.  
3 Q. HE SAID THERE WAS SOME THICKENING AND ASSOCIATED  
4 SCARRING; RIGHT?  
5 A. I DON'T REMEMBER HIS EXACT TERMINOLOGY, BUT HE  
6 RECOGNIZED, AS I DO, THAT THE SCAN IS ABNORMAL.  
7 Q. AND THE ABNORMALITY COULD BE THE RESULT OF  
8 RADIATION THAT MS. HENLEY RECEIVED?

9 A. IT COULD BE, ALTHOUGH THE TYPICAL SCARRING THAT  
10 YOU SEE FROM RADIATION IS THE LINEAR SCARRING THAT'S PRESENT  
11 THERE.  
12 THE DENSITY IS NOT THE DENSITY ADJACENT TO THE  
13 AORTA THAT WOULD BE IN A TYPICAL FINDING OF RADIATION  
14 FIBROSIS. WHAT YOU'D NORMALLY SEE IS LINEAR SCARRING.  
15 Q. I WANT TO MAKE SURE YOU WERE TELLING THE JURY  
16 THAT, BASED ON THIS CT SCAN THAT WAS TAKEN OCTOBER 10TH OF  
17 1998, THERE WAS A MASS IN THE LUNG?  
18 A. THERE IS DENSITY ADJACENT TO THE AORTA.  
19 Q. IS THAT A MASS IN THE LUNG, DOCTOR?  
20 A. YOU CAN INTERPRET THAT AS A MASS.  
21 Q. THAT'S NOT THE WAY THEY INTERPRETED IT, THOUGH?  
22 A. I DON'T KNOW HOW THEY INTERPRETED IT. BUT  
23 CLEARLY, THERE'S A DENSITY ADJACENT TO THE AORTA WHICH IS  
24 ABNORMAL, DOES NOT BELONG THERE.  
25 Q. DID YOU NOT REVIEW THEIR REPORT OF THAT CT SCAN?  
26 A. I KNOW I DID, YEAH.  
27 Q. AND DO YOU RECALL IT SAYING THAT NO DEFINITE MASS  
28 IS IDENTIFIED?

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0050

1 A. IT IS NOT DEFINITELY A MALIGNANCY. IT IS  
2 POSSIBLE THAT IT COULD REPRESENT SCARRING ASSOCIATED WITH  
3 RETRACTION OF THE MALIGNANCY AND SOME RESIDUAL SCARRING.  
4 BUT I'M HIGHLY SUSPICIOUS THAT THAT REPRESENTS  
5 RECURRENCE OF THE MALIGNANCY.  
6 Q. I UNDERSTAND WHAT YOUR OPINION IS, DOCTOR.  
7 WHAT I WANT YOU TO DO IS -- DO YOU RECALL WHAT  
8 THEIR OPINION WAS?  
9 A. I DON'T REMEMBER THEIR EXACT TERMINOLOGY.  
10 Q. DO YOU WANT ME TO SHOW IT TO YOU?  
11 A. THAT'S FINE.  
12 MR. OHLEMAYER: LET ME HAND YOU WHAT WE'LL MARK  
13 AS DEFENDANT'S NEXT IN ORDER FOR IDENTIFICATION.  
14 THE CLERK: DEFENDANT'S EXHIBIT 2798.  
15 (DOCUMENT MORE PARTICULARLY  
16 DESCRIBED IN THE INDEX MARKED  
17 FOR IDENTIFICATION DEFENDANT'S  
18 EXHIBIT # 2798)  
19 MR. OHLEMAYER: Q. LET ME HAND YOU WHAT I'VE  
20 MARKED FOR IDENTIFICATION, DOCTOR, AS 2798.  
21 ISN'T THE IMPRESSION OF THE DOCTOR WHO SIGNED  
22 THIS REPORT: "NO DEFINITE MASS IS IDENTIFIED"?  
23 A. "NO DEFINITE PULMONARY PARENCHYMAL NODULES ARE  
24 PRESENT. SCARRING IS SEEN IN THE ANTERIOR ASPECT  
25 OF LEFT UPPER LOBE AS WELL ADJACENT TO THE AORTIC  
26 PULMONARY WINDOW."  
27 Q. AND THERE'S A BIG ALL-CAPITALS WORD THAT SAYS  
28 "IMPRESSION"; RIGHT?

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0051

1 A. RIGHT.  
2 Q. WITH A COLON BY IT?  
3 A. RIGHT.  
4 Q. AND IT SAYS: "SOFT TISSUE THICKENING IN THE  
5 AORTIC PULMONARY WINDOW WITH ASSOCIATED  
6 SCARRING. NO DEFINITE MASS IS IDENTIFIED";  
7 RIGHT?  
8 A. RIGHT.  
9 Q. THANK YOU, DOCTOR. NOW, LET ME BACK UP FOR A  
10 MINUTE.  
11 AM I CORRECT, YOU WERE ASKED BY MS. HENLEY'S

12 ATTORNEYS TO EXAMINE HER; RIGHT?  
13 A. RIGHT.  
14 Q. YOU WEREN'T REFERRED BY -- NONE OF HER TREATING  
15 DOCTORS REFERRED HER TO YOU?  
16 A. NO.  
17 Q. YOU DIDN'T PRESCRIBE ANY TREATMENT FOR HER?  
18 A. NO.  
19 Q. YOU DIDN'T MAKE ANY REPORT OF ANY OF YOUR  
20 FINDINGS OR OPINIONS TO HER DOCTORS; RIGHT?  
21 A. NO.  
22 Q. OKAY. AND YOU TOLD US THAT YOU'RE OFTEN ASKED TO  
23 EXAMINE PATIENTS FOR MEDICAL/LEGAL REASONS; RIGHT?  
24 A. YES.  
25 Q. AND IT'S NOT UNUSUAL FOR YOU AND DR. HAMMAR TO BE  
26 INVOLVED IN THE SAME CASE; RIGHT?  
27 A. NOT UNUSUAL.  
28 Q. AND YOU HAVE DONE THAT MANY TIMES; RIGHT?

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0052

1 A. I COULDN'T TELL YOU HOW MANY. IT'S NOT UNUSUAL.  
2 Q. AND YOU TOLD MS. HENLEY -- OR MS. CHABER YOU'RE  
3 CHARGING HER FOR YOUR TIME.  
4 WHAT IS THE HOURLY RATE ON THAT?  
5 A. \$400 AN HOUR.  
6 Q. LET ME ASK YOU ABOUT SMALL CELL CARCINOMA.  
7 AM I CORRECT THAT, BY DEFINITION, A SMALL CELL  
8 CARCINOMA IS A CANCER THAT STARTS IN EPITHELIAL TISSUE?  
9 A. YES.  
10 Q. AND EPITHELIAL TISSUE IS LOCATED IN A VARIETY OF  
11 PLACES THROUGHOUT THE BODY?  
12 A. MANY, MANY PLACES.  
13 Q. AND HOW THICK IS THE BRONCHIAL EPITHELIAL, THAT  
14 IS THE EPITHELIAL TISSUE IN THE AIRWAYS?  
15 A. IT'S VERY THIN (INDICATING). ACTUALLY, I CAN'T  
16 TELL YOU HOW MANY MICRONS. IT'S VERY THIN.  
17 Q. AND A MICRON IS 1,000TH OF A MILLIMETER?  
18 A. YEAH. A MILLIONTH OF A METER.  
19 Q. A MILLIONTH OF A METER?  
20 A. RIGHT.  
21 Q. THE SYMPTOMS OF A PATIENT WHO HAS A SMALL CELL  
22 CARCINOMA THAT STARTS IN THE LUNG WOULD BE SIMILAR TO THOSE  
23 OF A PATIENT WHO HAD A SMALL CELL CARCINOMA THAT WAS OUTSIDE  
24 THE LUNG; RIGHT?  
25 A. WELL, IT WOULD DEPEND UPON WHERE IT STARTED  
26 OUTSIDE THE LUNG.  
27 SO LET'S SAY YOU HAVE A MALIGNANCY THAT STARTS IN  
28 THE GI TRACT SOMEWHERE. IT WOULDN'T BE UNUSUAL FOR

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0053

1 INDIVIDUALS TO PRESENT WITH NONSPECIFIC SYMPTOMS, SUCH AS  
2 WEIGHT LOSS, WEAKNESS, LOSS OF APPETITE, JUST KIND OF NO  
3 ENERGY WHATSOEVER.  
4 IT WOULD BE UNUSUAL IN SUCH A SITUATION FOR  
5 INDIVIDUALS TO HAVE SPECIFIC CHEST SYMPTOMS, LIKE CHEST  
6 PAIN, OR HEMOPTYSIS OR SHORTNESS OF BREATH, UNLESS THEY  
7 PRESENTED WITH METASTASES WHERE THEY COULD BE SHORT OF  
8 BREATH, BUT THEY WOULDN'T BE COUGHING UP BLOOD.  
9 Q. AND EVEN THAT SYMPTOMATOLOGY -- YOU MENTIONED  
10 NONSPECIFIC SYMPTOMS.  
11 THOSE ARE SYMPTOMS THAT AREN'T SPECIFIC TO A  
12 SPECIFIC DISEASE?  
13 A. WEAKNESS, WEIGHT LOSS, LOSS OF APPETITE IS NOT A  
14 SYMPTOM FOR A SPECIFIC DISEASE. MANY DISEASES PRESENT THAT

15 WAY.  
16 Q. AND THEN, THERE ARE OTHER SYMPTOMS THAT AREN'T  
17 UNIQUE TO A DISEASE BUT MAKE YOU SUSPICIOUS OF A CERTAIN  
18 DISEASE?  
19 A. RIGHT.  
20 Q. AND COUGHING AND COUGHING UP BLOOD ARE THOSE  
21 KINDS OF SYMPTOMS?  
22 A. THAT'S CORRECT.  
23 Q. NOW, WITH SYMPTOMS LIKE THAT, A DOCTOR IS LIKELY  
24 TO ORDER A CHEST X-RAY OR A CT SCAN; RIGHT?  
25 A. RIGHT. MAYBE NOT INITIALLY. IF YOU GO TO YOUR  
26 DOCTOR COMPLAINING OF COUGH, THE DOCTOR MAY NOT ORDER X-RAYS  
27 RIGHT AWAY. HE MAY TREAT YOU. HE MAY THINK YOU HAVE A  
28 RESPIRATORY INFECTION AND TREAT YOU FOR IT AND THEN, IF YOU

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0054

1 HAVE PERSISTENT SYMPTOMS, PROCEED TO EVALUATE YOU.  
2 Q. AND THEN, THE X-RAY MAY NOT NECESSARILY TELL THE  
3 DOCTOR WHAT YOUR SPECIFIC PROBLEM IS EITHER; RIGHT?  
4 A. ARE YOU ASKING ME IN GENERAL OR AS IT RELATES TO  
5 SMALL CELL CARCINOMA, OR WHAT?  
6 Q. LET'S TALK ABOUT AN ABNORMAL CHEST X-RAY.  
7 DOES THAT NECESSARILY GIVE A DOCTOR ENOUGH  
8 INFORMATION TO DECIDE A PATIENT HAS A LUNG CANCER?  
9 A. NO.  
10 Q. AND LIKEWISE, WITH A CT SCAN?  
11 A. RIGHT.  
12 Q. SO AFTER THAT, THE DOCTOR MIGHT CONDUCT WHAT YOU  
13 CALLED A BRONCHOSCOPY; RIGHT?  
14 A. RIGHT.  
15 Q. AND AS I THINK YOU TOLD US IN YOUR DEPOSITION,  
16 NOWADAYS, BRONCHOSCOPY IS VERY EASY AND THE EQUIPMENT IS  
17 VERY GOOD?  
18 A. RIGHT.  
19 Q. MOST OF THE TIME -- IN FACT, I THINK YOU TOLD US  
20 THAT YOU'VE BEEN INVOLVED IN AN ENORMOUS NUMBER OF CASES  
21 WITH PEOPLE WHO HAVE CANCER THAT BEGINS IN THEIR LUNG?  
22 A. RIGHT.  
23 Q. MOST OF THE TIME WHEN YOU DIAGNOSE A CANCER THAT  
24 BEGINS IN SOMEBODY'S LUNG, YOU DO SO BASED ON A BIOPSY;  
25 RIGHT?  
26 A. ALMOST ALWAYS A BIOPSY IS DONE IN ORDER TO MAKE A  
27 SPECIFIC DIAGNOSIS, BECAUSE THAT'S THE ONLY WAY YOU'LL KNOW  
28 THAT THAT IS THE DIAGNOSIS.

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0055

1 NOW, IN VERY UNUSUAL CIRCUMSTANCES, WE MIGHT BE  
2 SATISFIED WITH A PRESUMED DIAGNOSIS, BECAUSE THE BIOPSY  
3 PROCEDURE MIGHT BE TOO DANGEROUS BECAUSE OF OTHER DISEASE  
4 BEING PRESENT.  
5 BUT, YOU KNOW, WAY OVER 99 PERCENT OF THE TIME, I  
6 WON'T MAKE A DIAGNOSIS WITHOUT A SPECIFIC BIOPSY.  
7 Q. AND MOST OF THE TIME, THAT BIOPSY IS OBTAINED  
8 THROUGH THE USE OF A BRONCHOSCOPE?  
9 A. I WOULDN'T SAY "MOST OF THE TIME." I WOULD SAY  
10 FREQUENTLY.  
11 MANY INDIVIDUALS PRESENT WITH NODULES THAT ARE  
12 PRESENT PERIPHERALLY, OUT IN THE LUNG, AND THAT THE  
13 PROCEDURE OF CHOICE IS A NEEDLE BIOPSY RATHER THAN  
14 BRONCHOSCOPY.  
15 Q. MEANING A TUMOR THAT IS SOMEWHERE OUT IN THE  
16 LUNG, NOT IN THE AIRWAYS?  
17 A. RIGHT.

18 Q. NOW, WHEN --  
19 A. WELL, IT MAY VARY. BUT IF IT'S IN THE AIRWAY FAR  
20 ENOUGH OUT THAT YOU'RE NOT GOING TO GET TO IT, IT WOULD BE  
21 DIFFICULT TO GET IT BY BRONCHOSCOPY.  
22 Q. IN A SITUATION LIKE THAT, WHERE YOU ARE USING THE  
23 NEEDLE, YOU TAKE AN X-RAY OR CT SCAN TO HELP GUIDE YOU TO  
24 WHERE YOU WANT TO PUT THE NEEDLE?  
25 A. RIGHT.  
26 Q. WHEN YOU DO A BRONCHOSCOPY IN A PATIENT WHO HAS  
27 SMALL CELL CARCINOMA THAT STARTS IN THE LUNG, WHAT YOU, DR.  
28 HORN, TYPICALLY FIND IS AN ENDOBRONCHIAL LESION; RIGHT?  
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0056

1 A. I COMMONLY FIND ENDOBRONCHIAL LESIONS. I DON'T  
2 ALWAYS FIND THEM, BECAUSE I MAY NOT GET TO THEM, BUT I  
3 COMMONLY FIND THEM.  
4 Q. WELL, THE REASON I USED THE WORD "TYPICALLY,"  
5 THAT'S THE WORD YOU USED IN YOUR DEPOSITION.  
6 DO YOU RECALL THAT?  
7 A. WELL, I DON'T REMEMBER WHAT I USED, BUT IT ISN'T  
8 UNUSUAL TO FIND A LESION.  
9 ON THE OTHER HAND, YOU MIGHT NOT, BECAUSE YOU MAY  
10 NOT BE ABLE TO GET TO IT BECAUSE OF THE INVOLVEMENT OF THE  
11 AIRWAY, NARROWING OF THE AIRWAY. IT MAY OCCUR IN A PORTION  
12 OF THE AIRWAY THAT YOU CAN'T GET TO WITH A BRONCHOSCOPE.  
13 Q. I WANT TO TAKE THAT A STEP AT A TIME.  
14 AM I CORRECT, DOCTOR, THAT WHEN YOU BRONCHOSCOPE  
15 A PATIENT FOR SMALL CELL CARCINOMA OF THE LUNG, YOU  
16 TYPICALLY FIND A LESION IN THE BRONCHI, IN THE AIRWAY?  
17 A. NO. I OFTEN DO.  
18 BUT A SIGNIFICANT PORTION OF THE TIME -- AND I  
19 CAN'T TELL YOU HOW MUCH -- I MAY NOT SEE A LESION.  
20 NOW, IN THAT CIRCUMSTANCE, I WILL TYPICALLY DO A  
21 NEEDLE BIOPSY ANYWAY, BECAUSE I MAY MAKE THE DIAGNOSIS  
22 BECAUSE IT MAY BE PRESENT IN THE SUBMUCOSAL TISSUE, EVEN  
23 THOUGH THE LINING OF THE AIRWAY THAT I CAN SEE APPEARS  
24 NORMAL.  
25 Q. LET ME SEE IF YOU AGREE WITH THIS MUCH, DOCTOR,  
26 BEFORE WE GET THE TRANSCRIPTS OUT.  
27 WHEN YOU DO A BIOPSY USING A BRONCHOSCOPE IN  
28 SOMEBODY WHO HAS A SMALL CELL CARCINOMA OF THE LUNG, YOU  
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0057

1 EITHER TYPICALLY FIND A TUMOR, A LESION INSIDE THE BRONCHUS,  
2 OR YOU SEE COMPRESSION OR NARROWING OF THE AIRWAY CAUSED BY  
3 THE GROWTH OF THE TUMOR AROUND THE AIRWAY?  
4 A. YES.  
5 Q. OKAY.  
6 A. OR IN SOME WAY, THE AIRWAY MAY BE ABNORMAL. I  
7 MAY NOT SEE ACTUALLY AN ENDOBRONCHIAL -- I MAY NOT SEE A  
8 SPECIFIC LESION.  
9 FREQUENTLY, YOU CAN BRONCHOSCOPE PEOPLE. YOU  
10 LOOK AT THIS THING THROUGH THE BRONCHOSCOPE AND YOU SAY:  
11 "THIS IS A MALIGNANCY."  
12 OFTEN YOU WILL SEE THAT WITH SMALL CELL  
13 CARCINOMA. BUT, YOU KNOW, I AGAIN WOULD SAY OFTEN YOU DO  
14 NOT.  
15 Q. BUT WHAT YOU TOLD ME AT YOUR DEPOSITION WAS THAT  
16 YOU TYPICALLY EITHER FIND A TUMOR IN THE AIRWAY OR YOU FIND  
17 COMPRESSION OR YOU FIND SOME OTHER ABNORMALITY IN THE AIRWAY  
18 WHEN YOU DO THE BRONCHOSCOPE?  
19 A. THAT'S RIGHT.  
20 Q. IN MS. HENLEY'S CASE, THE DOCTOR WHO DID THE

21 BRONCHOSCOPY DIDN'T SEE A TUMOR IN THE BRONCHUS, DIDN'T SEE  
22 COMPRESSION, DIDN'T SEE ANY ABNORMALITY IN THE AIRWAY?  
23 A. HE DID. HE DESCRIBED AN ABNORMALITY IN THE LEFT  
24 UPPER LOBE. THE LEFT UPPER LOBE WAS ABNORMAL.  
25 HE DIDN'T BIOPSY IT BECAUSE HE WENT ON TO DO A  
26 MEDIASTINOTOMY, BUT THE LEFT UPPER LOBE WAS ABNORMAL.  
27 Q. LET ME HAND YOU DEFENDANT'S EXHIBIT 2791, WHICH  
28 IS THE REPORT DONE BY THE DOCTORS WHO DID THE BRONCHOSCOPY.  
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0058

1 AND LET ME ASK YOU TO CONFIRM FOR ME THAT IT SAYS  
2 THAT: "NO OBVIOUS ENDOBRONCHIAL LESIONS WERE SEEN. THE  
3 REST OF THE BRONCHIAL TUBE ALSO REVEALED NO ABNORMAL  
4 LESIONS"?  
5 A. (EXAMINING)  
6 "A BRONCHOSCOPE WAS INSERTED DOWN THE  
7 ENDOTRACHEAL TUBE. A SECTION OF THE AIRWAY  
8 SHOWED THAT SHE HAD A MILD INFLAMMATION OF HER  
9 LEFT UPPER LOBE BRONCHUS; HOWEVER, NO OBVIOUS  
10 ENDOBRONCHIAL LESIONS WERE SEEN."  
11 THE LEFT UPPER LOBE WAS ABNORMAL. THERE WAS NO  
12 CLEAR-CUT ENDOBRONCHIAL MALIGNANT LESION, BUT THE LEFT UPPER  
13 LOBE WAS ABNORMAL.  
14 Q. THERE WAS NO COMPRESSION?  
15 A. HE DOES NOT DESCRIBE COMPRESSION, ALTHOUGH YOU  
16 CAN SEE IT ON CT SCAN.  
17 Q. THERE WAS NO COMPRESSION DESCRIBED BY THE DOCTOR  
18 WHO DID THE BRONCHOSCOPY; RIGHT?  
19 A. THAT'S CORRECT. THERE WAS NO CLEAR-CUT  
20 COMPRESSION ON THE CT SCAN.  
21 Q. DOCTOR, PLEASE ANSWER THE QUESTION.  
22 THE COURT: YOU NEED TO CONFINE YOUR ANSWER TO  
23 THE QUESTION.  
24 MR. OHLEMEYER: Q. THERE WAS NO DESCRIPTION OF  
25 NARROWING OF THE BRONCHUS; RIGHT?  
26 A. NO.  
27 Q. THERE WAS NO DESCRIPTION OF THIS MOUNDING, OR  
28 SUBMUCOSAL MOUNDING; RIGHT?

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0059

1 A. THAT'S CORRECT.  
2 Q. THERE WAS NO DESCRIPTION OF -- I THINK THESE WERE  
3 YOUR WORDS -- GETTING THE SCOPE STUCK IN THE BRONCHIAL  
4 TUBES; RIGHT?  
5 A. THAT'S CORRECT.  
6 Q. ALL RIGHT. DOCTOR, WITH RESPECT TO MS. HENLEY'S  
7 SYMPTOMS, THERE IS SOME INCONSISTENCY IN THE MEDICAL RECORDS  
8 ABOUT HER HEMOPTYSIS OR HER COUGHING UP BLOOD; RIGHT?  
9 A. FROM THE STANDPOINT OF THE TIMING, THERE'S SOME  
10 INCONSISTENCY, BUT THERE ARE MULTIPLE NOTES IN THE RECORD  
11 INDICATING THAT SHE HAD HEMOPTYSIS.  
12 Q. YOU RECALL A RECORD WHERE SHE DENIES HAVING  
13 HEMOPTYSIS?  
14 A. YES.  
15 Q. YOU RECALL A RECORD WHERE SHE DESCRIBES ONE  
16 EPISODE OF HEMOPTYSIS?  
17 A. YES.  
18 Q. YOU RECALL A RECORD WHERE SHE TELLS DR. SMITH SHE  
19 HAS NO HEMOPTYSIS?  
20 A. CORRECT.  
21 Q. ALL RIGHT. AM I CORRECT THAT THE HILUM IS A  
22 PLACE WHERE THE ARTERIES AND THE NERVES AND THE BRONCHI  
23 ENTER THE LUNG? RIGHT?

24 A. YES.  
25 Q. IT'S AN AREA OF THE BODY?  
26 A. RIGHT.  
27 Q. THE MEDIASTINUM IS THE AREA OF THE BODY BETWEEN  
28 THE LUNGS; RIGHT?

JUDITH ANN OSSA, CSR NO. 2310

0060

1 A. RIGHT.  
2 Q. AND AM I CORRECT, DOCTOR, THAT NO LUNG PRIMARY  
3 WAS DESCRIBED BY X-RAY CT SCAN OR INTRAOP, WHICH MEANS BY  
4 THE SURGICAL PROCEDURES PERFORMED ON MS. HENLEY?  
5 A. THERE WAS A HILAR MASS DESCRIBED BY X-RAY, WHICH  
6 IS THE CLASSIC RADIOGRAPHIC ABNORMALITY THAT YOU SEE IN  
7 INDIVIDUALS WITH SMALL CELL CARCINOMA.  
8 Q. LET ME HAND YOU DEFENDANT'S -- PREVIOUSLY  
9 ADMITTED INTO EVIDENCE, DEFENDANT'S EXHIBIT 2793, WHICH IS  
10 THE DISCHARGE RECORD ON MS. HENLEY.  
11 HAVE YOU SEEN THAT RECORD BEFORE?  
12 A. PROBABLY. I DON'T RECALL.  
13 Q. TAKE A LOOK UP THERE, NEAR THE TOP.  
14 DOESN'T IT SAY "NO PRIMARY IDENTIFIED BY CT OR  
15 INTRAOP"?  
16 A. (EXAMINING)  
17 CORRECT.  
18 Q. AND THE BIOPSY THAT WAS GIVEN TO THE PATHOLOGIST  
19 IN THIS CASE TO LOOK AT DURING MS. HENLEY'S  
20 MEDIASTINOTOMY --  
21 A. RIGHT.  
22 Q. -- WAS NOT LUNG TISSUE; RIGHT?  
23 A. PROBABLY NOT, BUT I'M NOT SURE WHAT WAS BIOPSIED.  
24 Q. WELL, DO YOU RECALL ME ASKING YOU THAT QUESTION  
25 AT YOUR DEPOSITION AT PAGE 69, COUNSEL, LINE 24?  
26 THE COURT: HAS THIS BEEN LODGED WITH THE  
27 COURT?  
28 DO YOU KNOW WHAT I MEAN?

JUDITH ANN OSSA, CSR NO. 2310

0061

1 MR. OHLEMEYER: I KNOW WHAT YOU MEAN.  
2 I THOUGHT WHAT YOU WANTED TO DO IS -- I'LL HAND  
3 UP A COPY.  
4 THE COURT: ALL RIGHT. I'M GOING TO GIVE IT TO  
5 TATSUO WHEN I FINISH WITH IT.  
6 WE NEED A COPY LODGED WITH COURT FOR THE OFFICIAL  
7 RECORD.  
8 MR. OHLEMEYER: I CAN GIVE YOU TWO, IF YOU WANT.  
9 THE COURT: ALL RIGHT.  
10 MS. CHABER: WHAT WERE THE LINES?  
11 MR. OHLEMEYER: PAGE 69, LINE 24 THROUGH PAGE  
12 70, LINE 4.  
13 THE COURT: WHAT IS THE DATE OF THE DEPOSITION?  
14 MR. OHLEMEYER: THE DATE OF THE DEPOSITION, YOUR  
15 HONOR, IS DECEMBER 14TH, 1998.  
16 THE COURT: OKAY.  
17 ANY OBJECTION TO THAT BEING READ?  
18 MS. CHABER: NO.  
19 THE COURT: YOU MAY READ.  
20 MR. OHLEMEYER: Q. THE QUESTION I ASKED YOU,  
21 DOCTOR, WAS: "WHAT WAS IT THAT WAS BIOPSIED IN MS. HENLEY'S  
22 CASE?"  
23 YOUR ANSWER WAS: "MEDIASTINOSCOPY. SO LYMPH  
24 NODES IN THE MIDDLE OF THE CHEST WERE BIOPSIED."  
25 MY NEXT QUESTION: "IT WASN'T LUNG TISSUE, WAS  
26 IT?"

27 YOUR ANSWER WAS: "OH, NO."  
28 AM I CORRECT, THERE WAS NO BIOPSY OF LUNG TISSUE  
JUDITH ANN OSSA, CSR NO. 2310

0062

1 IN THIS CASE?  
2 A. WELL, ACTUALLY, UPON REFLECTION, I'M NOT SURE,  
3 BECAUSE THE SURGEON SAID THAT THEY BIOPSIED A HILAR MASS,  
4 AND IT'S NOT SPECIFIC WHAT WAS BIOPSIED.  
5 TYPICALLY, WHAT SURGEONS BIOPSY IN THIS SITUATION  
6 ARE LYMPH NODES, BUT I'M NOT SURE WHAT THE SURGEON BIOPSIED.  
7 Q. BUT YOU KNOW IT WASN'T LUNG TISSUE?  
8 A. I WOULD SAY I DON'T KNOW THAT. I DON'T KNOW WHAT  
9 PRECISELY WAS BIOPSIED.  
10 Q. IN DECEMBER OF 1998, YOU TOLD ME IT WASN'T LUNG  
11 TISSUE; RIGHT?  
12 A. I DID. BUT I'M NOW SITTING WITH THE SURGEON'S  
13 REPORT, AND I'M NOT SURE WHAT THE SURGEON BIOPSIED.  
14 Q. AND THE PATHOLOGIST WHO LOOKED AT THIS SPECIMEN  
15 UNDER THE MICROSCOPE DESCRIBED IT AS A SMALL CELL CARCINOMA;  
16 RIGHT?  
17 A. RIGHT.  
18 Q. NOW, MS. HENLEY ALSO UNDERWENT SOME TESTS TO SEE  
19 IF THE CANCER SHE HAD HAD SPREAD TO OTHER ORGANS; RIGHT?  
20 A. RIGHT.  
21 Q. THAT'S BECAUSE CANCER CAN SPREAD TO OTHER PARTS  
22 OF THE BODY; RIGHT?  
23 A. IT TYPICALLY DOES.  
24 Q. AND SMALL CELL CARCINOMA THAT STARTS IN THE LUNG  
25 TYPICALLY SPREADS TO THE BRAIN, DOESN'T IT?  
26 A. YES.  
27 Q. TO BONE?  
28 A. YES.

JUDITH ANN OSSA, CSR NO. 2310

0063

1 Q. TO PORTIONS OF -- TO ORGANS IN THE ABDOMEN, LIKE  
2 THE LIVER AND THE ADRENAL GLANDS?  
3 A. YES.  
4 Q. AND IN THIS CASE, A SCAN WAS DONE OF MS. HENLEY'S  
5 BRAIN THAT WAS NEGATIVE?  
6 A. RIGHT.  
7 Q. A SCAN OF HER BONE WAS NEGATIVE?  
8 A. RIGHT.  
9 Q. THE CT SCAN OF HER ABDOMEN WAS NEGATIVE?  
10 A. RIGHT.  
11 Q. SHE WAS AND IS SEEING AN ONCOLOGIST; RIGHT?  
12 A. RIGHT.  
13 Q. WHO IS A DOCTOR WHO TREATS PEOPLE WITH CANCER?  
14 A. THAT'S CORRECT.  
15 Q. AND THE TREATMENT FOR HER WAS CHEMOTHERAPY AND  
16 RADIATION?  
17 A. RIGHT.  
18 Q. AND THAT'S THE USUAL TREATMENT FOR SOMEBODY WHO  
19 HAS A CANCER THAT CAN'T BE OPERATED ON?  
20 A. WELL, AT LEAST THIS CANCER. WHAT SHE RECEIVED  
21 WAS, SHE RECEIVED TREATMENT FOR SMALL CELL CARCINOMA OF THE  
22 LUNG.  
23 Q. OKAY. WELL, WHAT SHE RECEIVED WAS THE USUAL  
24 TREATMENT FOR AN INOPERABLE SMALL CELL CARCINOMA, REGARDLESS  
25 OF WHERE IT MIGHT HAVE STARTED; RIGHT?  
26 A. I DON'T HAVE THE EXPERTISE TO ANSWER THAT.  
27 Q. NOW, THERE ARE TUMORS OR CANCERS THAT CAN START  
28 IN THE MEDIASTINUM; RIGHT?

JUDITH ANN OSSA, CSR NO. 2310

0064

1 A. RIGHT.  
2 Q. JUST A COUPLE MORE QUESTIONS, DOCTOR.  
3 YOU SAID SOMETHING EARLIER ABOUT DIFFUSION  
4 CAPACITY?  
5 A. RIGHT.  
6 Q. NOW, HYPOXEMIA, WHAT IS WHAT?  
7 A. A REDUCED AMOUNT OF OXYGEN IN THE BLOOD.  
8 Q. OR ANEMIA CAN CAUSE A DECREASED DIFFUSION  
9 CAPACITY; RIGHT?  
10 A. ANEMIA CAN RESULT IN REDUCED DIFFUSING CAPACITY.  
11 HYPOXEMIA MAY BE THE OUTCOME OF HAVING ENOUGH LUNG DISEASE  
12 TO RESULT IN REDUCED DIFFUSING CAPACITY.  
13 Q. MS. HENLEY COULD HAVE BEEN ANEMIC FROM HER CANCER  
14 TREATMENT; RIGHT?  
15 A. SHE WAS ANEMIC FROM HER CANCER TREATMENT.  
16 Q. AND THAT COULD BE THE CAUSE OF HER DECREASED  
17 DIFFUSING CAPACITY; RIGHT?  
18 A. NO, BECAUSE WE CORRECTED FOR THAT WHEN WE DID THE  
19 DIFFUSING CAPACITY MEASUREMENT IN OUR LABORATORY. WE  
20 MEASURED HER HEMOGLOBIN, AND SHE WAS IN FACT ANEMIC WHEN SHE  
21 WAS IN OUR LAB ON AUGUST 11TH AND THE RESULT IS CORRECTED  
22 FOR HER HEMOGLOBIN. HER DIFFUSING CAPACITY IS IN FACT  
23 REDUCED BECAUSE OF DISEASE IN HER LUNGS AND NOT BECAUSE SHE  
24 IS ANEMIC.  
25 Q. PRIOR TO DECEMBER OF 1997, MS. HENLEY DIDN'T HAVE  
26 A HISTORY OF OR ANY SYMPTOMS OF EMPHYSEMA; RIGHT?  
27 A. THAT'S CORRECT. WITHIN THE CONTEXT OF HOW SHE  
28 CONDUCTED HER LIFE, SHE WAS NOT SHORT OF BREATH.

JUDITH ANN OSSA, CSR NO. 2310

0065

1 MR. OHLEMEYER: THAT'S ALL I HAVE, YOUR HONOR.  
2 THANK YOU, DOCTOR.  
3 THE COURT: OKAY. MS. CHABER, THE QUESTION IS:  
4 CAN YOU FINISH BEFORE 4:30 OR NOT?  
5 MS. CHABER: I CAN.  
6 THE COURT: YOU CAN?  
7 MS. CHABER: I CAN.  
8 THE COURT: ALL RIGHT. YOU MAY.  
9 IF WE'RE DONE WITH DR. HORN'S DRAWING, LET'S MARK  
10 IT AS PLAINTIFF'S 43 FOR IDENTIFICATION ONLY.  
11 MAYBE TATSUO COULD GIVE YOU A STICKER.  
12 THE CLERK: YES.  
13 (DOCUMENT MORE PARTICULARLY  
14 DESCRIBED IN THE INDEX MARKED  
15 FOR IDENTIFICATION PLAINTIFF'S  
16 EXHIBIT # 43)  
17 THE COURT: WE MARKED THAT PLAINTIFF'S 43 FOR  
18 IDENTIFICATION. TATSUO WILL PUT A STICKER ON IT.  
19 MS. CHABER: THIS IS YOUR LAST CHANCE TO FIX IT  
20 UP BEFORE THE STICKER GOES ON IT.  
21 THE COURT: ARE YOU GOING TO HAVE HIM MARK ON  
22 IT?  
23 MS. CHABER: NO. I'M COMMENTING ON HIS ARTWORK  
24 AND THE INFORMATION.  
25  
26 REDIRECT EXAMINATION  
27 BY MS. CHABER: Q. DR. HORN, A LEFT HILAR  
28 MASS, WHAT IS THAT INDICATIVE OF?

JUDITH ANN OSSA, CSR NO. 2310

0066

1 A. THAT'S AN ABNORMALITY. THAT'S THE TYPICAL  
2 FINDING YOU FIND IN SOMEONE WHO HAS A MALIGNANCY ARISING

3 FROM EPITHELIAL CELLS IN A LARGE AIRWAY.  
4 Q. THE LARGE AIRWAY HAS TO DO WITH THE LUNG?  
5 A. RIGHT.  
6 Q. THE REPORTS YOU WERE ASKED ABOUT, THE CT SCAN  
7 REPORT AND THE SURGICAL REPORT AND THE PATHOLOGY REPORT FROM  
8 THE HOSPITAL, THOSE WERE ALL PIECES OF INFORMATION THAT WERE  
9 THEN PUT TOGETHER BY MS. HENLEY'S TREATING PHYSICIANS;  
10 CORRECT?  
11 A. RIGHT.  
12 Q. AND THE CONCLUSION THAT THEY REACHED AFTER THEY  
13 PUT ALL THAT TOGETHER WAS THAT SHE HAD LUNG CANCER; CORRECT?  
14 A. CORRECT. ALL OF HER TREATING PHYSICIANS HAVE  
15 CONCLUDED THAT SHE HAS LUNG CANCER.  
16 Q. YOU WERE BEING ASKED ABOUT COMPRESSION, AND THAT  
17 THERE WAS NO NOTE IN THE SURGICAL REPORT ABOUT COMPRESSION.  
18 AND I THOUGHT YOU SAID SOMETHING ABOUT BEING ABLE  
19 TO SEE IT ON THE CT SCAN.  
20 A. THE CT SCAN DEMONSTRATES THAT HER -- THE DISTAL  
21 PORTION OF HER LEFT MAINSTEM BRONCHUS IS NARROWED.  
22 Q. YOU CAN SEE THAT FROM THE VIEW ON THE CT SCAN?  
23 A. YES.  
24 Q. THE FACT THAT IT IS NOT COMMENTED UPON IN THE  
25 SURGICAL REPORT, IS THAT INCONSISTENT WITH THAT?  
26 A. I DON'T KNOW WHY IT WASN'T COMMENTED ON. IT'S  
27 CLEARLY THERE.  
28 Q. AND THE NOTATION IN THE SURGERY REPORT, IS THAT  
JUDITH ANN OSSA, CSR NO. 2310

0067

1 CONSISTENT WITH THERE BEING AN ABNORMALITY THAT IS A LUNG  
2 CANCER?  
3 A. THE SURGEON DESCRIBES A HILAR MASS, WHICH WAS  
4 BIOPSIED.  
5 Q. AND WHEN THE PATHOLOGIST GAVE HIS INTERPRETATION  
6 OF IT BEING A SMALL CELL CANCER, HE NOTED THAT IT WAS A  
7 SMALL CELL CANCER THAT CAME FROM THE HILAR MASS; CORRECT?  
8 A. RIGHT.  
9 Q. AND WOULD THAT BE INDICATIVE OF IT BEING A LUNG  
10 CANCER OR OF IT BEING SOMETHING ELSE?  
11 A. THIS IS THE TYPICAL PRESENTATION FOR SOMEONE WHO  
12 HAS A SMALL CELL MALIGNANCY OF THE LUNG.  
13 Q. AND FINALLY, MR. OHLEMEYER ASKED YOU ABOUT THE  
14 SPREAD OF SMALL CELL CANCER OF THE LUNG AND THAT THE BONE  
15 SCAN WAS CLEAR AND THE BRAIN SCAN WAS CLEAR.  
16 DOES THAT MEAN THERE'S NO SPREAD?  
17 A. NO. IT MEANS THAT THERE ISN'T GROSS SPREAD  
18 WITHIN CONTEXT OF OUR ABILITY TO MAKE A DIAGNOSIS.  
19 WE DON'T SEE IT, BUT THAT DOESN'T MEAN THERE  
20 HASN'T BEEN MICROSCOPIC SPREAD TO THOSE ORGANS.  
21 Q. AND IN FACT, WHEN THEY LABELED THE DISEASE, THEY  
22 LABELED IT AS LIMITED SMALL CELL CARCINOMA OF THE LUNG?  
23 A. YES. WE USE THAT TERMINOLOGY WHEN WE, WITHIN OUR  
24 LIMITATION OF BEING ABLE TO MAKE A DIAGNOSIS, THAT DISEASE  
25 APPEARS TO BE LIMITED TO THE CHEST. BUT WE KNOW THAT IT'S  
26 NOT JUST LIMITED TO THE CHEST.  
27 Q. AND IN FACT, IF THE RECOMMENDATION IS TO DO BRAIN  
28 RADIATION TO THE BRAIN --  
JUDITH ANN OSSA, CSR NO. 2310

0068

1 A. RIGHT.  
2 Q. -- WHAT'S THE REASON FOR DOING THAT?  
3 A. BECAUSE --  
4 MR. OHLEMEYER: I OBJECT TO THAT, YOUR HONOR.  
5 AS FRAMED, IT'S ASKING THE WITNESS TO SPECULATE ABOUT THE

6 STATE OF MIND OF ANOTHER DOCTOR.  
7 THE COURT: YES. SUSTAINED.  
8 MS. CHABER: Q. IS THAT A TYPICAL  
9 RECOMMENDATION FROM A SMALL CELL CANCER OF THE LUNG, THAT  
10 THERE IS A RECOMMENDATION FOR RADIATION TO BE DONE?  
11 A. YES.  
12 Q. RADIATION TO THE BRAIN, THAT IS?  
13 A. YES.  
14 Q. AND WHY IS THAT?  
15 A. BECAUSE THE INCIDENCE OF METASTATIC SPREAD TO THE  
16 BRAIN IS SO HIGH THAT MOST PHYSICIANS RECOMMEND PROPHYLACTIC  
17 WHOLE BRAIN RADIATION.  
18 Q. WHEN YOU SAY "PROPHYLACTIC," WHAT DO YOU MEAN?  
19 A. YOU DO IT TO PREVENT FURTHER SPREAD OF THE  
20 MICROSCOPIC DISEASE TO BECOME GROSS DISEASE, WHERE PEOPLE  
21 BECOME SYMPTOMATIC.  
22 Q. YOU WERE ASKED ABOUT HYPOXEMIA.  
23 A. RIGHT.  
24 Q. WHAT IS THAT?  
25 A. A REDUCED AMOUNT OF OXYGEN IN THE BLOOD.  
26 Q. HOW IS THAT MEASURED?  
27 A. BY MEASURING THE AMOUNT OF OXYGEN IN THE BLOOD.  
28 GETTING AN ARTERIAL BLOOD SPECIMEN, AND MEASURING THE AMOUNT  
JUDITH ANN OSSA, CSR NO. 2310

0069

1 OF OXYGEN.  
2 Q. AND DID MS. HENLEY HAVE LESS OXYGEN IN HER BLOOD  
3 THAN SHE NORMALLY SHOULD HAVE?  
4 A. A LITTLE BIT LESS. WHAT ISN'T A PROBLEM WILL BE  
5 A PROBLEM. IT WASN'T A PROBLEM WHEN I SAW HER IN AUGUST,  
6 BUT IT WAS REDUCED A LITTLE BIT.  
7 Q. OKAY. AND THIS DIFFUSING CAPACITY THAT YOU  
8 TALKED ABOUT, THAT'S THE LUNG'S ABILITY TO EXCHANGE OXYGEN  
9 AND CARBON DIOXIDE?  
10 A. IT'S REALLY A REFLECTION OF THE MATCHING OF  
11 OXYGEN AND BLOOD, AIR AND BLOOD IN THE LUNG. THE REDUCED  
12 DIFFUSING CAPACITY IS A REFLECTION OF THE FACT THAT THERE IS  
13 MISMATCHING OF THE AIR AND THE BLOOD.  
14 Q. OKAY. AND IN HER CASE, THAT WAS DUE TO WHAT?  
15 A. EMPHYSEMA.  
16 MS. CHABER: THAT'S ALL THE QUESTIONS I HAVE.  
17 THE COURT: OKAY.  
18 ANYTHING FURTHER, MR. OHLEMEYER?  
19 MR. OHLEMEYER: NOTHING FURTHER, YOUR HONOR.  
20 THE COURT: MAY DR. HORN BE EXCUSED?  
21 MS. CHABER: YES.  
22 MR. OHLEMEYER: YES, HE MAY.  
23 THE COURT: OKAY. DR. HORN, YOU ARE EXCUSED.  
24 THE WITNESS: THANK YOU.  
25 (WITNESS EXCUSED)  
26 THE COURT: COUNSEL, IN A MINUTE, WHEN I LET THE  
27 JURY GO, I'M GOING TO NEED YOU TO CLEAN YOUR DESKS VERY  
28 QUICKLY, BECAUSE I NEED TO GET STARTED ON MY NEXT MATTER  
JUDITH ANN OSSA, CSR NO. 2310

0070

1 RIGHT AWAY.  
2 JURORS, OVER THE COURSE OF THE EVENING, PLEASE  
3 CONTINUE TO FOLLOW THE ADMONITION. I DO HAVE ANOTHER MATTER  
4 TOMORROW MORNING PRIOR TO THIS CASE.  
5 SO I'M GOING TO START WITH YOU AT 9:30, AND WE'RE  
6 GOING TO GO UNTIL 5:00 O'CLOCK TOMORROW.  
7 SO HAVE A GOOD EVENING. PLEASE CONTINUE TO  
8 FOLLOW THE ADMONITION. WE'LL SEE YOU AT 9:30 TOMORROW

9 MORNING.

10 (THE PROCEEDINGS ADJOURNED AT 4:30 P.M.)  
11  
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